HEALTH HISTORY & REGISTRATION

Today's Date _____

PATIENT INFORMATION

NAME Last _____ First _____ Middle Initial____ Nickname _____

Residential Status Full Time_____ Part Time_____

Local Address_____ City_____ State_____ Zip _____

Out of State Address_____ City_____ State_____ Zip _____

Cell Phone_____ Home Phone_____ Work Phone_____

Email_____ Preferred Method of Contact _____

Social Security #_____ Birthdate_____ Sex: Male_____ Female_____

Who is responsible for this account_____ Relationship to Patient_____

Do you have a healthcare surrogate or someone that helps you make decision? Yes_____ No_____

Name of Surrogate_____ Tel. # _____

Whom may we thank for referring you to our office? _____

PATIENT'S SIGNATURE_____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co._____

Insurance Co. Address_____

Insurance Tel._____

Insured's Employer _____

Insurance ID # _____

Soc. Sec. # _____ Group #_____ Local #____

Insured's Date of Birth _____

DENTAL INSURANCE INFORMATION (Secondary Carrier)

Insured's Name _____

Insurance Co._____

Insurance Co. Address_____

Insurance Tel._____

Insured's Employer _____

Insurance ID # _____

Soc. Sec. # _____ Group #_____ Local #____

Insured's Date of Birth _____

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin	Local Anesthetic	Erythromycin	Latex (balloons,
Nitrous Oxide	Codeine	Penicillin	gloves, etc.)

Are you aware of being allergic to any other medications or substances? _____

If yes, please list: _____

Please list all medications you are currently taking.

_____

_____

_____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes_____ No_____

Name of physician or dentist making recommendation: _____

Phone: _____

Pre-Medicate _____

Amox _____ Clindamycin _____

Other _____

EMERGENCY CONTACT INFORMATION:

NAME _____ RELATIONSHIP _____

ADDRESS _____

CITY, STATE _____ PHONE_____

MEDICAL HISTORY	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐
For what?		

Physician's Name

Telephone No.

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

Heart Disease or Attack	CVA/TIA (Stroke)	Emphysema
Angina Pectoris	Osteoporosis/Osteopenia	Tuberculosis (TB)
High Blood Pressure	Sexually Transmitted Disease	Asthma
Low Blood Pressure	AIDS/ARC/HIV Pos.	Hay Fever
Heart Murmur	Hepatitis A (infectious)	Sinus Trouble
Rheumatic Fever	Hepatitis B (serum)	Allergies or Hives
Congenital Heart	Hepatitis C	Diabetes Type I or II
Mitral Valve Prolapse	Liver Disease	Thyroid Disease
Pacemaker	Blood Transfusion	Alzheimer's/Dementia
Artificial Heart Valve	Drug Addiction	Eating Disorder
Heart Pacemaker	Hemophilia (Bleeding Problems)	Arthritis
Heart Surgery	Fever Blisters	PREGNANT
Artificial Joints (Hip, Knee)	Epilepsy or Seizures	Depression
Date_____	Nervousness	Alcoholism
Anemia	Psychiatric Treatment	Cosmetic Surgery
Stroke	Glaucoma	Severe Headaches/Migraines
Kidney Trouble	Cancer/Chemotherapy/Radiation	
Ulcers	Bruise Easily	