PATIENT REGISTRATION & HEALTH HISTORY FORM

Please complete the following confidential information:

How did you hear about our office? ________________________

Patient or responsible party, if patient is a minor

Name ____ Home Phone: (_____)______________________
First Name Initial Last Name

Address: ____
Street City State Zip

Social Security #____ Date of Birth: ___________________________________

Employer____ Work Phone & Ext: ______________________________

Occupation: ______________________________ Business Address: ____
City, State, Zip

Cell Phone: ________________________________ Driver's License No. ______________________________

Email Address: ____________________________________

Spouse

Name: ____ Home Phone: (_____)______________________
First Name Initial Last Name

Address: ____
Street City State Zip

Social Security #____ Date of Birth: ___________________________________

Employer:____ Work Phone & Ext: __________________________

Occupation: ______________________________ Business Address: ____
City, State, Zip

Cell Phone: _______________________________ Driver's License No. ____________________________________

Child (if child is patient)

Name ____ **Home Phone: _(_____)**____________________________

Address: ____
City, State, Zip

Date of Birth: ____________ Age _____ Sex _____ School ___________________City _________________ Grade ______

Dental Insurance

Primary Insurance Company: ____________________________ Address:____

Employee: ____________________________ Social Security #:_____-___-______ Member # :___________ Group #: ________

Secondary Insurance Company: ___________________________ Address:____

Employee: ____________________________ Social Security #:_____-___-______ Member # :___________ Group #: ________

In Case of emergency contact:

Name: ____

Address: ____ **Phone #: (_____)**________________________

Is another member of your family a patient at our practice? Yes_____ No ______ Name: ________________________________

NOTES: CC:

MEDICAL AND DENTAL HEALTH HISTORY

1. Are you experiencing dental pain or discomfort? Yes __ No __
2. Are you in good health? Yes __ No __
3. Has there been a change in your general health within the past year? Yes __ No __
4. Are you under the care of a physician? Yes __ No __
   If so, what condition (s) is being treated?____
   Physician's Name ______________________________________Phone #____________________
   Address: ____
5. Have you been hospitalized or had a serious operation or illness within the last 5 years?
6. Do you have or have you had any of the following diseases or problems? Please circle all that apply.

Heart Failure		Diabetes		Emphysema	
Heart Disease or Attack		Thyroid Disease		Cough	
Angina Pectosis		High Blood Pressure		Tuberculosis (TB)	
X-ray or Cobalt Treatment		Chemotherapy		Asthma	
Sickle Cell Disease		Arthritis		Sinus Trouble	
Congenital Heart Lesions		Cortisone Medicine		Allergies or Hives	
Psychiatric Treatment		Heart Murmur		Glaucoma	
Scarlet Fever		Mitral Valve Prolapse		Artificial Joint	
Artificial Heart Valve		Pain In Jaw Joints		Anemia	
Fainting or Dizzy Spells		Epilepsy / Seizures		Heart pacemaker	
Heart Surgery		Stroke		Kidney Trouble	
HIV Positive		Cold Sores		AIDS	
STD or VD (Syphilis or Gonorrhea)		Ulcers		Bruise Easily	
Hepatitis A (Infectious)		Blood Transfusion		Rheumatic Fever	
Hepatitis B (Serus)		Liver Disease		Hay Fever	
Hepatitis C				Nervousness	

7. Are you taking any drug or medicine?_____ If so, what ____
8. Are you allergic or have you reacted adversely to any drugs or medicines? Yes __ No __
9. When you walk up stairs or take a walk, do you ever have to stop because of pain in chest? Yes __ No __
10. Do your ankles swell during the day? Yes __ No __
11. Have you had any serious trouble associated with previous dental treatment? Yes __ No __
    If so, please explain____
12. Have you had abnormal bleeding associated with previous dental treatment? Yes __ No __
13. Do you have a disease, condition or problem not listed above that you think I should know? Yes __ No __
    If so, please explain ____

For Women Only – Are You Pregnant Yes __ No __

If yes, what month are you? ____________________________

Are you taking birth control pills? Yes __ No __

CONSENT: As the undersigned, I hereby authorize Doctor to, after thorough explanation, take radiographs, study models, photographs or any other diagnostic aids, deemed appropriate by Doctor to make a diagnosis of my dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated (after they are discussed with me) and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I authorize the office to transmit any and all information necessary to my insurance company for the means of payment by electronic or other means. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependent(s) is mine, due and payable at the time of services rendered. If for any reason my account becomes not current, I will pay any legal fees the office incurs to collect said fees.

Signature of Patient, Parent of Responsible Party: ____

Relationship:______________________________Date: ______________________ Reviewed ____________________________