

Registration/Health History Form

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Patient Name: _____ Date of Birth _____

Single Married Widowed Divorced Child

Address: _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Cell (_____) _____

E-Mail _____ Social Security # _____

Employer _____

Phone (_____) _____ Ext: _____ Present position _____

How should we contact you? Home phone Cell phone E-mail Text

Best time to contact you? Morning Afternoon Evening Other: _____

In case of an emergency, who should be notified? _____ Phone (_____) _____

Financial Responsibility and Dental Insurance Information

Person Responsible for Payment:

Name _____ Relationship to patient _____

Primary Dental Insurance Information

Name of Insured _____

Is insured a patient? Yes No

Patient's relationship to insured:
 Self Spouse Child Other _____

Insured's Birth Date _____

ID # _____ Group # _____

Insured's Social Security # _____

Insured's Address (if different than patient's)

Insured's Employer Name _____

Insurance Plan Name _____

Phone Number _____

Secondary Dental Insurance Information

Name of Insured _____

Is insured a patient? Yes No

Patient's relationship to insured:
 Self Spouse Child Other _____

Insured's Birth Date _____

ID # _____ Group # _____

Insured's Social Security # _____

Insured's Address (if different than patient's)

Insured's Employer Name _____

Insurance Plan Name _____

Phone Number _____

Dental Information-

For the following questions, please mark (X) for your responses to the following questions. **(Check DK if you Don't know the answer to the question)**

	Yes	No	DK
Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently experiencing dental pain or discomfort? ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you brux or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No	DK
Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you participate in active recreational activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medical Information (cont.)-

Please mark (X) for your response to indicate if you have or have not had any of the following diseases or problems.

Allergies- Are you allergic to or have you had a reaction to:

To all **YES** responses, specify type of reaction.

Yes No DK			Yes No DK				
Local anesthetics.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates, sedatives or sleeping pills..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Metals.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/seasonal.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animals.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food/Nuts.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other(s).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Yes No DK			Yes No DK				
Cardiovascular disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Chemotherapy/Radiation Treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	--Specify:.....			
Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain upon exertion.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes- Type I or Type II.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G.E. Reflux/persistent heartburn.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other congenital heart defects.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapsed.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (circle type) A B C.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells or seizures.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--If yes date:.....				--Specify:.....			
Hemophilia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	--Specify:.....			
Autoimmune Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	--Type of Infection:.....			
Systemic Lupus Erythematosus....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema/ COPD.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent swollen glands in neck.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches/migraines.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe or rapid weight loss.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice or liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other(s):.....							

Who may we thank for referring you? _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any actions they take or do not take because of errors or omissions that I may have made in the completion of this form. I understand this document will be scanned and that a print out will be considered the original document.

Signature of Patient/Legal Guardian:

Date: