

# HEALTH HISTORY & REGISTRATION

## WELCOME TO OUR PRACTICE

Patients Name \_\_\_\_\_ Sex:  M  F

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Please Check One:  Single  Married  Separated  Divorced  Widowed

Occupation \_\_\_\_\_ Home Phone Number \_\_\_\_\_

Your Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Your Social Security # \_\_\_\_\_ Cell Phone \_\_\_\_\_

Are you a full time student?  Yes  No E-mail \_\_\_\_\_

If Patient is a minor we need: Mother's Birth Date \_\_\_\_\_ Father's Birth Date \_\_\_\_\_

Name of Spouse (Parent if Minor) \_\_\_\_\_ Person Responsible For Account \_\_\_\_\_

Spouse's (Parents') Employer \_\_\_\_\_ Relationship \_\_\_\_\_ Social Security \_\_\_\_\_

Spouse's Social Security # \_\_\_\_\_ Work Phone \_\_\_\_\_

Spouse's Birth Date \_\_\_\_\_

Referred to us by \_\_\_\_\_

Reason for this visit \_\_\_\_\_

|   |
|---|
| <b>EMERGENCY INFORMATION</b><br>Name, Address & Telephone of a Relative not living with you |
|   |
|   |
|   |

## DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insurance Co. Phone \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insured's Social Security Number \_\_\_\_\_ Policy # \_\_\_\_\_ Group# \_\_\_\_\_ Local# \_\_\_\_\_

### If you have double dental Insurance coverage complete this for the second coverage.

Insured's Name \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insurance Co. Phone \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insured's Social Security Number \_\_\_\_\_ Policy # \_\_\_\_\_ Group# \_\_\_\_\_ Local# \_\_\_\_\_

# MEDICAL HISTORY

Do you have any CURRENT HEALTH PROBLEMS? YES  NO

Are you under a PHYSICIAN'S CARE now? YES  NO

For what? \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

Are you currently taking any medication? YES  NO

If yes, what? \_\_\_\_\_

Ever had a serious illness or major surgery: \_\_\_\_\_

## Circle any of the following which you have had or have at present:

|                               |                   |   |                    |
|-------------------------------|-------------------|---|--------------------|
| Heart Disease or Attack       | Blood Disorders   | Epilepsy or Seizures                            | Tuberculosis (TB)  |
| High Blood Pressure           | Sickle Cell       | Fainting or Dizzy Spells                        | Asthma             |
| Low Blood Pressure            | Stroke            | Nervousness                                     | Hay Fever          |
| Heart Murmur                  | Kidney Trouble    | Psychiatric Treatment                           | Sinus Trouble      |
| Rheumatic Fever               | Ulcers            | Glaucoma  | Allergies or Hives |
| Congenital heart Lesions      | A.I.D.S.          | Radiation Treatment                             | Diabetes           |
| Artificial Heart Valve        | Hepatitis         | Chemotherapy                                    | Arthritis          |
| Heart Pacemaker               | Liver Disease     | Cancer  | Rheumatism         |
| Heart Surgery                 | Blood Transfusion | Venereal Disease (Syphilis,<br>Gonorrhea, etc.) | Cortisone Medicine |
| Artificial Joints (Hip, Knee) | Hemophilia        | Emphysema                                       | Pain in Jaw Joints |
| Anemia                        | Fiber Blisters    |   |                    |

## Are you allergic or have you reacted adversely to any of the following medications?

|               |                  |              |            |            |
|---------------|------------------|--------------|------------|------------|
| Aspirin       | Ibuprofen        | Codeine      | Penicillin | Any Metals |
| Nitrous Oxide | Local Anesthetic | Erythromycin | Latex      |            |

Are you aware of being allergic to any other medications or substances? If yes, Please list: \_\_\_\_\_

Is there any other medical or dental information that you feel I should know about? \_\_\_\_\_

## CONSENT:

The undersigned hereby authorizes Doctor to take necessary X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that the responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge will be added to any overdue balance. I also assign all insurance benefits to the Doctor.

PATIENT Signature (Parent of Child) \_\_\_\_\_ Date: \_\_\_\_\_ DENTIST Signature \_\_\_\_\_