HEALTH HISTORY & REGISTRATION

Title: Mr., Mrs., Ms. _____
Patient's Name _____ Home Phone Number ( ) - _____
Work Number ( ) - _____ Email _____
Home Address _____ Cell Number ( ) - _____
City _____ State _____ Zip _____
Social Security # _____ Sex: M F Age _____ Birth date ___/___/___
Occupation _____
Employer (Parents if minor) _____
Name of Spouse (Parent if minor) _____
Spouse's Work Phone Number (Parent if minor) ( ) - _____
Referred to us by _____ Reason for Visit _____

EMERGENCY INFORMATION:
Contact Name _____ Daytime Phone Number _____
Address _____

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit 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.

MEDICAL INFORMATION

	Yes	No
Are you in good health?	❑	❑
Has there been any change in your general health within the past year?	❑	❑
Are you now under the care of a physician?	❑	❑

If yes, what is/are the condition(s) being treated? _____

_____

Date of last physical examination: _____

Physician: _____ Town _____

Have you had any serious illness, operation, or been hospitalized in the past 5 years? ❑ ❑

If yes, what was the illness or problem? _____

_____

_____

Are you allergic to or have had a reaction to?	**Yes**	**No**
Local anesthetics	❑	❑
Aspirin	❑	❑
Penicillin or other antibiotics	❑	❑
Barbiturates, sedatives, or sleeping pills	❑	❑
Sulfa drugs	❑	❑
Codeine or other narcotics	❑	❑
Latex	❑	❑
Iodine	❑	❑
Hay fever/seasonal	❑	❑
Animals	❑	❑
Food (specify) _____	❑	❑
Other (specify) _____	❑	❑
Metals (specify) _____	❑	❑

To yes responses, specify type of reaction. _____

_____

_____

Are you taking:

Recreational drugs?	❑ Yes	❑ No
Tobacco in any form?	❑ Yes	❑ No
Over-the-counter medicines, aspirins, natural remedies.	❑ Yes	❑ No
Alcohol	❑ Yes	❑ No

Please list any prescription drugs you are taking: _____

_____

_____

_____

Are you taking or have you ever taken any medication for Osteoporosis? ❑ Yes ❑ No

If yes, which drug and for how long? _____

_____

Have you taken a drug called Cortisone, Steroid, or ACTH within the past two years?	❑	❑
Have you ever taken any blood thinners in the past week?	❑	❑
Do you bruise easily or bleed excessively?	❑	❑
Can you take asprin, Advil, Motrin, ibuprofen?	❑	❑

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

If yes, why? _____

If yes, what antibiotic and dose? _____

_____

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

	Yes	No
Abnormal bleeding	❑	❑
AIDS or HIV infection	❑	❑
Anemia	❑	❑
Arthritis	❑	❑
Any radiation to head or neck	❑	❑
Asthma / C.O.P.D.	❑	❑
Blood Transfusion. If yes, date:_____	❑	❑
Cancer/Chemotherapy/Radiation Treatment	❑	❑
Cardiovascular disease. If yes specify below:	❑	❑

____ Angina
____ Arteriosclerosis
____ **Artificial heart valves**
____ Congenital heart defects
____ Congestive heart failure
____ Coronary artery disease
____ Damaged heart valves
____ Heart attack
____ Stents
____ Heart murmur
____ High blood pressure
____ Low blood pressure
____ Mitral valve prolapse
____ Pacemaker
____ Rheumatic heart disease/Rheumatic fever
____ Automatic Implantable Cardiodefibrillator (ACID, ICD)

Chest pain upon exertion	❑	❑
Chronic pain	❑	❑
Disease, drug, or radiation-induced immunosupression	❑	❑
Diabetes. If yes, specify below:	❑	❑
____ Type I (Insulin dependent) _____Type II		
Dry Mouth	❑	❑
Eating disorder. If yes specify:_____	❑	❑
Fainting spells	❑	❑
History of seizures	❑	❑
Reflux/GERD	❑	❑
Glaucoma	❑	❑
Do you have loose teeth, or full or partial dentures?	❑	❑
Do you have a chronic cough?	❑	❑
Do you cough up any material?	❑	❑

	Yes	No
Hemophilia	❑	❑
Hepatitis, jaundice or liver disease	❑	❑
Recurrent Infections	❑	❑
If yes, indicate type of infection:_____	❑	❑
Kidney problems	❑	❑
Mental health disorders. If yes, specify:_____	❑	❑
_____		
Night sweats	❑	❑
Neurological disorders. If yes, specify:_____	❑	❑
_____		
Osteoporosis	❑	❑
Persistent swollen glands in neck	❑	❑
Respiratory problems. If yes, specify below:	❑	❑
____Emphysema _____Bronchitis, etc.		
Severe headaches/migraines	❑	❑
Sexually transmitted disease	❑	❑
Sinus problems	❑	❑
Sleep disorder	❑	❑
Sores or ulcers in the mouth	❑	❑
Stroke	❑	❑
Systematic lupus erthematosus	❑	❑
Tuberculosis	❑	❑
Thyroid problems	❑	❑
Stomach Ulcers	❑	❑
Excessive urination	❑	❑

	Yes	No
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	❑	❑

If yes, when was this operation done?_____

If you answered yes to the above question, have you had any complications or difficulties with your prosthetic joint?_____

_____

WOMEN ONLY

Are you or could you be pregnant?	❑	❑
Nursing?	❑	❑
Taking birth control pills or hormonal replacement?	❑	❑

ALL PATIENTS

Do you have or have you had any other diseases or medical problems NOT listed on this form? ❑ Yes ❑ No

If so, please explain: _____

CONSENT:

The undersigned hereby authorizes Doctor to take 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. To my knowledge I have given an accurate report of my physical and mental health history. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental service 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 agree to pay 1.5% per month interest on any past due balance, and, in the case the account is referred for collection. I promise and agree to pay all costs of collection including, but not limited to a 15% collection agency fee, reasonable attorney fees and court costs. I also assign all insurance benefits to the Doctor.

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature: _____ Dentist signature: _____ Date _____

(Parent if patient is a minor)