

ADULT PATIENT - REGISTRATION

Patient's name _____ Birth date _____
First Middle Last

Street Address _____

City _____ State _____ Zip _____ Land Phone _____

Patient Cell Phone _____ Patient Work Phone _____ Ext _____

Patient e-mail address: _____

Patient employed by: _____ Social Security # _____

Name of spouse/partner _____ Birth date _____

Spouse Cell Phone _____ Spouse Work Phone _____ Ext _____

Spouse/partner employed by: _____ Social Security # _____

Contacts in case of emergency (not yourself or spouse):

Name: _____ Relationship: _____ Phone: _____ Cell: _____

Name: _____ Relationship: _____ Phone: _____ Cell: _____

INSURANCE:

Insurance Company _____ Employer _____

Policy Holder's name _____ Date of Birth _____

Policy/Contract No. _____ Group No. _____

2nd Insurance Company _____ Employer _____

Policy Holder's name _____ Date of Birth _____

Policy/Contract No. _____ Group No. _____

Please be prepared to provide for duplication: 1. Current Photo I.D. 2. Insurance cards (if applicable)

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

The undersigned agree(s) that in the event of default or that the account is placed with a collection agency for collection, he/she is responsible for reasonable attorney's fees, miscellaneous costs of collection, collection agency fees, court costs, service charges and/or interest as allowed by law.

Patient Signature: _____ Date _____

Updated: _____ Ini _____ Updated: _____ Ini _____ Updated: _____ Ini _____

Updated: _____ Ini _____

Entered by: _____ Checked by: _____

HEALTH HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name _____ Birth date _____ Age _____

Why are you now seeking dental treatment? _____

Please answer each question. Check yes or no. If in doubt, leave blank.

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Are you in good health now? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you now under the care of a physician? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, what is the condition being treated? | | |
| 3. Have you ever been hospitalized or had a serious illness?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, explain | | |
| 4. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. (Women) Are you pregnant? If so, give due date | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you use tobacco in any form? If yes, how much | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you use alcoholic beverages (more than 2 drinks per day)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have or have you ever had any of the following? | | |

- | GENERAL | YES | NO |
|--|--------------------------|--------------------------|
| Tire easily, weakness | <input type="checkbox"/> | <input type="checkbox"/> |
| Marked weight change | <input type="checkbox"/> | <input type="checkbox"/> |
| Night sweats | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent fever | <input type="checkbox"/> | <input type="checkbox"/> |
| SKIN | | |
| Eruptions (rash) hives | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in skin color | <input type="checkbox"/> | <input type="checkbox"/> |
| EYES | | |
| Visual change | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| EARS | | |
| Loss of hearing | <input type="checkbox"/> | <input type="checkbox"/> |
| Ringing in ears | <input type="checkbox"/> | <input type="checkbox"/> |
| NOSE | | |
| Frequent nosebleeds..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus problems | <input type="checkbox"/> | <input type="checkbox"/> |
| THROAT | | |
| Soreness/hoarseness | <input type="checkbox"/> | <input type="checkbox"/> |
| NERVOUS SYSTEM | | |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| Convulsions/epilepsy | <input type="checkbox"/> | <input type="checkbox"/> |
| Numbness/tingling..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizziness/fainting | <input type="checkbox"/> | <input type="checkbox"/> |
| Psychiatric treatment | <input type="checkbox"/> | <input type="checkbox"/> |
| RESPIRATORY | | |
| Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma/hay fever..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent cough | <input type="checkbox"/> | <input type="checkbox"/> |
| Sputum production (phlegm)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Cough up bloody sputum | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty breathing while lying down .. | <input type="checkbox"/> | <input type="checkbox"/> |
| ENDOCRINE | | |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Family history of diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid condition/goiter..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> |

- | HEART/BLOOD VESSELS | YES | NO |
|------------------------------------|--------------------------|--------------------------|
| Rheumatic fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart murmur | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest pain/discomfort | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart attack/trouble..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> |
| Swelling of ankles | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Congenital heart disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral valve prolapse | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial heart valve..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart surgery | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> |
| BONE/MUSCLES | | |
| Arthritis/rheumatism | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial joints/limbs..... | <input type="checkbox"/> | <input type="checkbox"/> |
| DIGESTIVE SYSTEM | | |
| Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Jaundice | <input type="checkbox"/> | <input type="checkbox"/> |
| Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in appetite | <input type="checkbox"/> | <input type="checkbox"/> |
| Black, bloody or pale stools | <input type="checkbox"/> | <input type="checkbox"/> |
| URINARY | | |
| Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> |
| increase in frequency | | |
| of urination (night) | <input type="checkbox"/> | <input type="checkbox"/> |
| Burning on urination | <input type="checkbox"/> | <input type="checkbox"/> |
| Urethral discharge..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Bloody urine | <input type="checkbox"/> | <input type="checkbox"/> |
| Venereal disease..... | <input type="checkbox"/> | <input type="checkbox"/> |
| BLOOD | | |
| Bruise easily | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood transfusion | <input type="checkbox"/> | <input type="checkbox"/> |
| OTHER | | |
| Latex sensitivity..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Radiation therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| Chemotherapy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Tumors or growths..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer..... | <input type="checkbox"/> | <input type="checkbox"/> |
| HIV+ | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS | <input type="checkbox"/> | <input type="checkbox"/> |
| Eating disorder | <input type="checkbox"/> | <input type="checkbox"/> |

Please complete reverse side

9. Are you ALLERGIC or have you ever experienced any reaction to the following?

	YES	NO		YES	NO
Local anesthetics (e.g. novocaine)	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin or codeine	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates/sedatives/sleeping pills ..	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin/other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	Other allergies		

10. Are you taking any of the following?

	YES	NO		YES	NO
Antibiotics/sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>	Tranquillizers	<input type="checkbox"/>	<input type="checkbox"/>
Blood thinners	<input type="checkbox"/>	<input type="checkbox"/>	Herbal supplements	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure medication	<input type="checkbox"/>	<input type="checkbox"/>	Insulin/other diabetes drugs	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid medication	<input type="checkbox"/>	<input type="checkbox"/>	Recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone/steroids	<input type="checkbox"/>	<input type="checkbox"/>	Digitalis/other heart medications.....	<input type="checkbox"/>	<input type="checkbox"/>
Antihistamines/allergy drugs/.....	<input type="checkbox"/>	<input type="checkbox"/>	Nitroglycerin	<input type="checkbox"/>	<input type="checkbox"/>
Pain medication.....	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>

If yes to any of the above, list name of medication and dosage below:

1. _____

2. _____

3. _____

4. _____

11. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain _____

12. Physician's Name _____ Phone _____

13. Have you ever had any serious trouble associated with previous dental treatment? _____

14. Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____

15. Date of last dental visit _____

16. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____

If so, when? _____

17. Do you have or have you ever had any of the following?

MOUTH		YES	NO	MOUTH		YES	NO
Bleeding, sore gums	<input type="checkbox"/>	<input type="checkbox"/>	Loose teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unpleasant taste/bad breath.....	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to hot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent blisters, lips/mouth	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning tongue/lips	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to sweets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swelling/lumps in mouth	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to biting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ortho treatments (braces).....	<input type="checkbox"/>	<input type="checkbox"/>	Food Impaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biting cheeks/lips	<input type="checkbox"/>	<input type="checkbox"/>	Clenching/grinding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clicking/popping jaw	<input type="checkbox"/>	<input type="checkbox"/>	Shifting of teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty opening or closing jaw	<input type="checkbox"/>	<input type="checkbox"/>	Change in bite.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ORAL HYGIENE

Do you use the following?	YES	NO
Brush.....	<input type="checkbox"/>	<input type="checkbox"/>
Dental floss	<input type="checkbox"/>	<input type="checkbox"/>
Fluoride rinse	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

How often do you brush? _____

Brush is: Soft Medium Hard

To the best of my knowledge, all of the preceding answers are true and correct.

If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient _____ Date _____

Parent, or Guardian _____