REGISTRATION FORM / MEDICAL-DENTAL HISTORY

PATIENT REGISTRATION FOR: ______________________________

Residence Address		
Telephone	Referred By	
Other Family Members in the Practice	Preferred Time for Appointments	
SSN	DOB / /	
Marital Status S M D W	Spouse's Name	
If Minor, Name of Guardian	Address & Telephone	
Person Responsible for Fee (if other than patient)		Relationship to Patient
Billing Address (if different from above)		
Occupation	Will you receive calls at work?	
Employer's Name & Telephone		
EMERGENCY NOTIFICATION Nearest Relative Not Living With You—Name & Telephone		

Medical Alert Sticker

INSURANCE INFORMATION

	Primary Carrier	Secondary Carrier
Name of Insurance Company	______	______
Address	______	______
Telephone	______	______
Subscriber's Name / Relationship to Patient	/	/
Name of Group Policyholder or Union	______	______
Group Policy # / Individual Policy #	/	/
Effective Date / Time Limit for Claims	/	/
Pre Estimate Required	☐ Yes ☐ No	☐ Yes ☐ No
Method of Payment	☐ UCR ☐ Schedule of Payments ☐ Other______	☐ UCR ☐ Schedule of Payments ☐ Other______
Coinsurance	Company____% Patient____%	Company____% Patient____%
Deductible	☐ Yes ☐ No ☐ Individual ☐ Family ☐ Annual $____ ☐ Lifetime $____	☐ Yes ☐ No ☐ Individual ☐ Family ☐ Annual $____ ☐ Lifetime $____
Plan Covers: Prophylaxis	☐ Yes ☐ No	☐ Yes ☐ No
Orthodontics	☐ Yes ☐ No	☐ Yes ☐ No
Other	______	______

If credit card payment is accepted: Name of Card______________________________

Card #______________________________ Expiration Date______________

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FORM # 2005A

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INSTRUCTIONS:

To receive treatment in this office you must answer all questions on this history form.

The questions asked relate directly to the safe and effective treatment you are to receive in the office—to the best of your ability honest answers must be given.

If you are unsure of the question, unsure of your answer, or whether the question relates to your medical condition, you are to discuss the matter with the doctor.

Some of the questions may not relate to you or your medical condition; in that event you are to write "N/A" (not applicable) in the space provided.

All questions must be answered.

Use the pen supplied by the office.

To properly evaluate your current health status it may be necessary for the dentist to contact your physician. Included on this form is "Permission To Release Information." You are asked to sign it in the presence of a member of the office staff.

ALL INFORMATION YOU SUPPLY TO THE OFFICE ON THIS FORM, AND THE SUBSEQUENT INTERVIEW BY THE DENTIST AND RECEIVED FROM YOUR PHYSICIAN OR ANY OTHER SOURCE, WILL BE HELD IN THE STRICTEST CONFIDENCE, AND WILL NOT BE DISCLOSED WITHOUT YOUR EXPRESS AND WRITTEN PERMISSION.

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1. Name, address & telephone # of your physician____________________
2. Date of last visit to your doctor__________ Purpose of visit__________
3. Do you suffer from any disability?__________ If yes, describe__________
4. Have you ever, or do you now take illegal drugs?__________ If yes, what drugs, and when taken?__________ *Note: There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal.*
5. Do you have AIDS, or are you HIV-positive?__________ If yes, describe and provide current status.__________
6. Do you now have, or have you ever had a venereal disease?__________ If yes, describe.__________
7. Have you ever had, or do you now have hepatitis?__________ If yes, describe.__________
8. For females: Are you pregnant?__________ If yes, when are you due?__________
9. For females: Are you taking birth control pills?__________ *Note: There are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills.*
10. Are you taking any drugs or medications?__________ If yes, list and describe amounts and purpose.__________ *Note: There are many drug and medication incompatibilities, some of which may result in dangerous health problems. Information about your current use of drugs and medication is essential.*
11. Have you ever had an allergic reaction to medication?__________ If yes, describe.__________
12. Have you lost weight recently?__________ If yes, describe.__________

Have You Ever Had Or Been Treated For:

13. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease?__________
14. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats?__________
15. Stomach or intestinal disease?__________
16. Abnormal blood pressure, excessive bleeding, or anemia?__________

17. Breathing problems, asthma, tuberculosis, or hay fever?

18. Cancer, X-ray treatments, or chemotherapy?

19. Diabetes?

20. Kidney problems or renal dialysis?

21. A stroke, convulsions, or fainting spells?

22. Tumors or growths?

23. Arthritis or rheumatism?

24. Have you ever had a major operation? If yes, describe.

25. Have you ever had a serious injury to your head or neck? If yes, describe.

26. Are you on a special diet? If yes, for what reason and describe.

27. Do you smoke? If yes, describe type and quantity.

28. Have you consulted or been treated by a psychiatrist, psychologist or counsellor? If yes, describe.

29. Are there any other problems about your health of which you are aware?

DENTAL HISTORY

Date of your last visit to a dentist

Reason for your last visit (or series of visits)

Do you have any of your X-rays or dental records?

In respect to any previous dental treatment have you:

30. Ever fainted?

31. Had an allergic reaction?

32. Had abnormal bleeding?

33. Any other complications during or following dental treatment? If yes, describe.

34. Do your gums bleed on brushing or eating?

35. Does food catch between your teeth?

36. Have your teeth shifted, are there spaces between your teeth now where there were none, are your teeth flaring, or are some of your teeth becoming loose?

37. Are any of your teeth sensitive to heat, cold, or pressure?

38. Do you grind your teeth or clench your jaws?

39. Do you have pain or clicking in the jaw joint around your ear?

40. Have your jaw muscles ever been sore? If yes, describe.

41. Are there any sores or growths in your mouth?

42. Do any of your teeth ache?

43. Do you have any other dental complaint?

NOTE: A change in your health status should be reported to the office at the earliest possible time.

To the best of my knowledge, the foregoing questions have been accurately answered.

Permission To Release Health Information

I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payors, and/or other health practitioners.

Person completing the form: Signature

Witness Print Name

If other than patient, indicate relationship Date / /

Dentist's History Review & Significant Findings

Signature Dr. Date