PATIENT REGISTRATION AND MEDICAL/DENTAL HISTORY

Medical Alert

Pharmacy Name__________ Phone__________

So that we may provide you with the best possible care, please complete both sides of this medical/dental history form.

(PLEASE PRINT)

Date__________

Home Phone__________ Work Phone__________ Cell/Pager__________ Email__________

Patient Name__________

Address__________

City__________ State______ Zip______ Social Security #__________ Driver's Lic.#__________

Sex: ❑ Male ❑ Female Age______ Birthday ___/___/___ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Employed By__________

Occupation__________

Business Address__________

City__________ State______ Zip______ Tel.__________

Spouse Name__________ Birthday ___/___/___

Employed By__________

Business Address__________

City__________ State______ Zip______ Tel.__________

Social Security #__________

Person Responsible For Account

Name: __________ Relation:__________

Billing Address: __________

Hm# (   )__________ DL#__________

Employer: __________

Wk# (   )__________ Ext:______ SS#__________

Dental Insurance Primary Carrier

Insured's Name __________ Social Security # __________

Insurance Company __________ Telephone __________

Address __________

City __________ State __________ Zip __________

Group Number __________ ID Number __________ Birthdate __________

Insured's Employer __________

Dental Insurance Secondary Carrier

Insured's Name __________ Social Security # __________

Insurance Company __________ Telephone __________

Address __________

City __________ State __________ Zip __________

Group Number __________ ID Number __________ Birthdate __________

Insured's Employer __________

In case of emergency, who should be notified?__________ Tel.__________

Whom may we thank for referring you?__________

Medical History

Physician's Name__________ Date of Last Physical__________

Address__________ Tel.__________

Please check the box of any condition you may have had.

❑ A.I.D.S./ HIV Positive or Other	❑ Back Problems	❑ Epilepsy/Seizures	❑ Hypoglycemia	❑ Rheumatic Fever
❑ Allergies to Anesthetics	❑ Blood Disease	❑ General Allergies* (List Below)	❑ Kidney Problem	❑ Sinus Problems
❑ Allergy to Colored Dyes	❑ Blood Transfusion	❑ Glaucoma	❑ Low Blood Pressure	❑ Special Diet
❑ Allergy to Latex	❑ Cancer, Leukemia	❑ Headaches	❑ Mitral Valve Prolapse	❑ Stroke
❑ Angina Pectoris	❑ Chemical Dependency	❑ Heart Disease or Attack	❑ Nervous Problems	❑ Swollen Neck Glands
❑ Arthritis/Rheumatism	❑ Chemotherapy/Radiation Therapy	❑ Heart Murmur	❑ Premedicate	❑ Thyroid Disease
❑ Artificial Heart Valves	❑ Chronic Diarrhea	❑ Heart Pacemaker	❑ Psychiatric Care	❑ Tuberculosis
❑ Artificial Joints	❑ Circulatory Problems	❑ Hemophilia	❑ Recent Weight Loss	❑ Ulcer
❑ Aspirin Taken Daily	❑ Contact Lenses	❑ Hepatitis, Jaundice or Liver Disease	❑ Respiratory Problem	❑ Venereal Disease
❑ Asthma	❑ Diabetes	❑ High Blood Pressure		❑ Other* (List below)

*General Allergies:__________

*Other: __________

Patient Name

DENTAL HISTORY

What is the reason for your visit today?__________

Is there anything about having dental treatment that you would like us to know? ❑ Yes ❑ No

If yes, please describe__________

Date of Last: **Dental Visit**_____ **Dental Cleaning**_____ **Full Mouth X-ray**_____ **Bitewing X-rays**_____

What treatment was done at your last dental visit?__________

Previous Dentist's Name__________ Telephone__________

Address__________

City__________ State__________ Zip Code__________

How often do you have dental examinations?__________ How often do you floss?__________

What other dental aids do you use? (Interplak, toothpick, etc.)__________

Do you have any dental problems now? ❑ Yes ❑ No If yes, please describe:__________

Circle "Yes" or "No" to each item

Do you:

- Clench or grind your teeth while awake or asleep? .... Yes No
- Bite your lips or cheeks regularly? .... Yes No
- Hold foreign objects with your teeth? .... Yes No (pencils, pipe, pins, nails, fingernails)
- Mouth breathe while awake or asleep? Yes No
- Have tired jaws, especially in the morning? .... Yes No
- Smoke/chew tobacco? .... Yes No
- How much?__________

Have you ever had:

- Orthodontic treatment? .... Yes No
- Oral surgery? .... Yes No
- Periodontal treatment? .... Yes No
- Your teeth ground or the bite adjusted? Yes No
- A bite plate or mouth guard? .... Yes No
- A serious injury to the mouth or head? Yes No
- If yes, please describe, including cause.

Are any of your teeth sensitive to:

- Hot or cold .... Yes No
- Sweet .... Yes No
- Biting or chewing .... Yes No

Have you noticed any mouth odors or bad tastes? .... Yes No

Do you frequently get cold sores, blisters or any other oral lesions? .... Yes No

Do your gums bleed or hurt? .... Yes No

Have your parents experienced gum disease or tooth loss? .... Yes No

Have you noticed any loose teeth or a change in your bite? .... Yes No

Do you have difficulty in chewing on either side of the mouth? .... Yes No

Does food tend to become caught in between your teeth? .... Yes No

If yes, where?__________

Have you ever experienced:

- Clicking or popping of the jaw? .... Yes No
- Pain? (joint, ear, side of face) .... Yes No
- Difficulty in opening or closing the mouth? Yes No
- Headaches, neckaches or shoulder aches? .... Yes No
- Sore muscles (necks, shoulders)? .... Yes No

Are you happy with your smile? .... Yes No

Are you pleased with the color of your teeth? Yes No

Would you like to keep all of your teeth all of your life? .... Yes No

Do you feel nervous about having dental treatment? .... Yes No

If yes, what is your biggest concern?__________

Have you ever had an upsetting dental experience? .... Yes No

If yes, please describe__________

Do you have any drug allergies or have you ever had an adverse reaction to any medication or substance? ❑ Yes ❑ No

If yes, list__________

Have you ever responded adversely to medical or dental treatment? ❑ Yes ❑ No

Have you ever been advised to be pre-medicated prior to any dental treatment? ❑ Yes ❑ No

Are you taking any medication at this time? ❑ Yes ❑ No If yes, what__________

Have you ever taken Phen-Fen? Or Redux? ❑ Yes ❑ No If so, have you seen a cardiologist for a consult since taking it? ❑ Yes ❑ No

Are you under the care of a physician? ❑ Yes ❑ No If yes, for what condition__________

If Patient is a child what is his/her weight? __________

Have you had a recent transfusion? ❑ Yes ❑ No

Is there anything else we should know about your medical history__________

Women — Are you: Pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

I verbally reviewed the medical / dental information above with the parent / guardian & patient named herein. __________

Staff /Dr.'s Initials Date

AUTHORIZATION AND RELEASE

The above information is accurate and complete to the best of my knowledge and is only for use in treatment, billing and processing of insurance for benefits for which I am entitled. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care, to third party payers and/or other health practitioners.

I authorize my insurance company to pay directly to the dental office the benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependents. __________

Signature of Patient or Parent of Minor Date