

Health History & Registration

Patient's Name _____ Sex: M F Birthdate _____ Age _____ Today's Date _____
 Home Address _____ City _____ State _____ Zip _____
 E-mail Address _____
 Please Circle One: Single Married Separated Widowed Occupation _____ Home Phone _____ Cell Phone _____
 Your Employer _____ How Long Employed? _____ Your Soc. Sec. # _____ Work Phone _____
 Are you a full time student? Y N If patient is a minor we need: Mother's Birthday _____ Father's Birthday _____
 Person Responsible for Account _____ Driver's License # _____
 Name of Spouse (Parent if Minor) _____
 Spouse's (Parent if Minor) Employer _____ Spouse's Soc. Sec. # _____ Spouse's DOB _____ Work Phone _____
 Referred to us by _____ Emergency Contact _____
 Reason for this visit _____
 Insurance Provider _____ Group # _____ Subscriber ID _____

It is important we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

Medical History	Yes	No	If yes, please explain:
Do you have any Current Health Problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you under a Physicians Care?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you currently taking any medication?	<input type="checkbox"/>	<input type="checkbox"/>	_____

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

- | | | |
|--------------------------|-------------------------|---------------------------|
| Acid Reflux | Emphysema | Mitral Valve Prolapse |
| ADHD | Epilepsy | Nervous Disorders |
| AIDS | Excessive Bleeding | Pacemaker |
| Anemia | Fainting | Pregnant – Due Date _____ |
| Angina Pectoris | Glaucoma | Psychiatric Treatment |
| Anxiety | Hay Fever | Radiation Treatment |
| Arthritis | Heart Disease/Attack | Respirator Problems |
| Artificial Heart Valve | Heart Murmur | Rheumatism |
| Artificial Joints | Heart Surgery | Seasonal Allergies |
| Asthma | Hepatitis A | Sinus Problems |
| Blood Disease | Hepatitis B | Sleep Apnea |
| Bruise Easily | High/Low Blood Pressure | Sleep Problems |
| Cancer | High Cholesterol | Snoring |
| Chemotherapy | HIV Positive | Stomach Problems |
| Cold Sores | Jaundice | Stroke |
| Congenital Heart Lesions | Jaw Joint Pain | Thyroid Disease |
| Depression | Kidney Disease | Tuberculosis |
| Diabetes | Liver Disease | Other |
| Dizziness | | |
| Drug Addiction | | |

CIRCLE IF YOU ARE ALLERGIC OR HAVE YOU REACTED ADVERSELY TO:

- | | | |
|---------------|------------------|--------------|
| Latex Allergy | Percodan | Erythromycin |
| Darvon | Local Anesthetic | Valium |
| Nitrous Oxide | Aspirin | Sulfa |
| Penicillin | Other _____ | |

Family Physician: _____ Physician Phone _____

Is there any other Medical or Dental information that you feel I should know about? _____

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. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents in mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance. I also assign all insurance benefits to the Doctor.

Patient Signature (parent if minor) _____ Date _____ Dentist Signature _____