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?	☐	☐	
Are you under a Physicians Care?	☐	☐	
Are you currently taking any medication?	☐	☐	

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

Acid Reflux
AIDS
Allergies
Anemia
Angina Pectoris
Anxiety
Arthritis
Artificial Heart Valve
Artificial Joints
Asthma
Blood Disease
Bruise Easily
Cancer
Chemotherapy
Cold Sores
Congenital Heart Lesions
Diabetes
Dizziness
Drug Addiction

Emphysema
Epilepsy
Excessive Bleeding
Fainting
Glaucoma
Hay Fever
Heat Disease/Attack
Heart Murmur
Heart Surgery
Hepatitis A
Hepatitis B
High/Low Blood Pressure
High Cholesterol
HIV Positive
Jaundice
Jaw Joint Pain
Kidney Disease
Liver Disease

Mitro Valve Prolapse
Nervous Disorders
Pacemaker
Pregnant – Due Date ______
Psychiatric Treatment
Radiation Treatment
Respirator Problems
Rheumatism
Sinus Problems
Sleep Apnea
Sleep Problems
Snoring
Stomach Problems
Stroke
Thyroid Disease
Tuberculosis
Other

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

Latex Allergy
Darvon
Nitrous Oxide
Penicillin

Percodan
Local Anesthetic
Aspirin
Other ______

Erythromycin
Valium
Sulfa

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 ______