

PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ DATE _____
FIRST MI LAST
ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
E-MAIL _____ CELL PHONE _____ HOME PHONE _____
SS#/SIN _____ BIRTHDATE _____
CHECK APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED
IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL _____ CITY _____ STATE/PROV. _____
PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER _____ WORK PHONE _____
BUSINESS ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
SPOUSE OR PARENT'S/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____
WHOM MAY WE THANK FOR REFERRING YOU? _____
PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____
ADDRESS _____ HOME PHONE _____
DRIVER'S LICENSE # _____ BIRTHDATE _____ SS#/SIN _____
EMPLOYER _____ WORK PHONE _____
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____
NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____
EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____
INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____
DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____
NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____
EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____
INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

X
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

PATIENT NUMBER

REGISTRATION

ITEM 07-0516767-27000

PATIENT MEDICAL HISTORY

PATIENT'S NAME _____

DATE OF BIRTH _____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

		YES	NO			YES	NO
1.	ARE YOU IN GOOD HEALTH	<input type="checkbox"/>	<input type="checkbox"/>	10.	HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION	<input type="checkbox"/>	<input type="checkbox"/>
2.	HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR	<input type="checkbox"/>	<input type="checkbox"/>	11.	HAVE YOU HAD A RECENT WEIGHT LOSS	<input type="checkbox"/>	<input type="checkbox"/>
3.	DATE OF YOUR LAST PHYSICAL EXAM: _____			12.	HAVE YOU EVER TAKEN FEN-PHEN/REDUX	<input type="checkbox"/>	<input type="checkbox"/>
4.	PHYSICIAN'S NAME _____ ADDRESS _____ PHONE NO. _____			13.	DO YOU USE TOBACCO	<input type="checkbox"/>	<input type="checkbox"/>
5.	ARE YOU NOW UNDER THE CARE OF A PHYSICIAN	<input type="checkbox"/>	<input type="checkbox"/>	14.	DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES	<input type="checkbox"/>	<input type="checkbox"/>
6.	HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS PLEASE EXPLAIN. _____	<input type="checkbox"/>	<input type="checkbox"/>	15.	ARE YOU WEARING CONTACT LENSES	<input type="checkbox"/>	<input type="checkbox"/>
7.	ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE IF YES, WHAT MEDICINE(S) ARE YOU TAKING _____	<input type="checkbox"/>	<input type="checkbox"/>	16.	DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)	<input type="checkbox"/>	<input type="checkbox"/>
8.	HAVE YOU HAD ANY ABNORMAL BLEEDING.	<input type="checkbox"/>	<input type="checkbox"/>	17.	DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT	<input type="checkbox"/>	<input type="checkbox"/>
9.	DO YOU BRUISE EASILY	<input type="checkbox"/>	<input type="checkbox"/>	WOMEN ONLY: ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT			
				ARE YOU NURSING			
				ARE YOU TAKING BIRTH CONTROL PILLS			

		YES	NO			YES	NO
ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:				HIVES OR SKIN RASH		<input type="checkbox"/>	<input type="checkbox"/>
	LOCAL ANESTHETICS LIKE NOVOCAINE	<input type="checkbox"/>	<input type="checkbox"/>	FADING OR DIZZY SPELLS		<input type="checkbox"/>	<input type="checkbox"/>
	PENICILLIN OR OTHER ANTIBIOTICS	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES		<input type="checkbox"/>	<input type="checkbox"/>
	SULFA DRUGS	<input type="checkbox"/>	<input type="checkbox"/>	AIDS OR HIV INFECTION		<input type="checkbox"/>	<input type="checkbox"/>
	BARBITURATES, SEDATIVES OR SLEEPING PILLS ..	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS		<input type="checkbox"/>	<input type="checkbox"/>
	ASPIRIN	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES		<input type="checkbox"/>	<input type="checkbox"/>
	IODINE	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS OR RHEUMATISM		<input type="checkbox"/>	<input type="checkbox"/>
	ANY METALS (E.G., NICKEL, MERCURY, ETC.)	<input type="checkbox"/>	<input type="checkbox"/>	JOINT REPLACEMENT OR IMPLANT		<input type="checkbox"/>	<input type="checkbox"/>
	LATEX / RUBBER	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH ULCER		<input type="checkbox"/>	<input type="checkbox"/>
	OTHER (PLEASE LIST) _____	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY TROUBLE		<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:				TUBERCULOSIS		<input type="checkbox"/>	<input type="checkbox"/>
	RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	PERSISTENT COUGH		<input type="checkbox"/>	<input type="checkbox"/>
	SCARLET FEVER	<input type="checkbox"/>	<input type="checkbox"/>	COUGH THAT PRODUCES BLOOD		<input type="checkbox"/>	<input type="checkbox"/>
	HEART DEFECT OR HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	CHEMOTHERAPY (CANCER, LEUKEMIA)		<input type="checkbox"/>	<input type="checkbox"/>
	HEART TROUBLE, HEART ATTACK, OR ANGINA ...	<input type="checkbox"/>	<input type="checkbox"/>	SEXUALLY TRANSMITTED DISEASE		<input type="checkbox"/>	<input type="checkbox"/>
	CHEST PAIN	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY OR SEIZURES		<input type="checkbox"/>	<input type="checkbox"/>
	SHORTNESS OF BREATH	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA		<input type="checkbox"/>	<input type="checkbox"/>
	PACEMAKER	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA		<input type="checkbox"/>	<input type="checkbox"/>
	HEART SURGERY	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUSNESS		<input type="checkbox"/>	<input type="checkbox"/>
	HIGH/LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	TONSILLITIS		<input type="checkbox"/>	<input type="checkbox"/>
	CONGENITAL HEART PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	TUMORS		<input type="checkbox"/>	<input type="checkbox"/>
	SWELLING OF FEET, ANKLES, HANDS	<input type="checkbox"/>	<input type="checkbox"/>	MENTAL HEALTH CARE		<input type="checkbox"/>	<input type="checkbox"/>
	HEPATITIS, JAUNDICE OR LIVER DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	BACK PROBLEMS		<input type="checkbox"/>	<input type="checkbox"/>
	STROKE	<input type="checkbox"/>	<input type="checkbox"/>	CHEMICAL DEPENDENCY		<input type="checkbox"/>	<input type="checkbox"/>
	SINUS TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	MITRAL VALVE PROLAPSE		<input type="checkbox"/>	<input type="checkbox"/>
	LUNG OR BREATHING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	CORTISONE TREATMENT		<input type="checkbox"/>	<input type="checkbox"/>
	ASTHMA OR HAY FEVER	<input type="checkbox"/>	<input type="checkbox"/>	COLD SORES/FEVER BLISTERS		<input type="checkbox"/>	<input type="checkbox"/>
				HYPOGLYCEMIA		<input type="checkbox"/>	<input type="checkbox"/>
				EATING DISORDERS		<input type="checkbox"/>	<input type="checkbox"/>

ITEM 07-081875/27011

PATIENT NUMBER _____

HEALTH HISTORY

PATIENT DENTAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT _____ WHAT WAS DONE THEN _____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN _____

PREVIOUS DENTIST (NAME AND LOCATION) _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN WHERE _____

HOW OFTEN DO YOU BRUSH YOUR TEETH _____ HOW OFTEN DO YOU FLOSS YOUR TEETH _____

IS YOUR DRINKING WATER FLUORIDATED _____

	YES	NO		YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING.....	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY.	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS.....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH.....	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS.....	<input type="checkbox"/>	<input type="checkbox"/>	DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH.....	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU FEEL PAIN TO ANY OF YOUR TEETH.....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS).....	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH.....	<input type="checkbox"/>	<input type="checkbox"/>	EVER WORN A BITE PLATE OR OTHER APPLIANCE ..	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES.	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST.....	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?			HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS.....	<input type="checkbox"/>	<input type="checkbox"/>
CLICKING.....	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU WEAR DENTURES OR PARTIALS.....	<input type="checkbox"/>	<input type="checkbox"/>
PAIN (JOINT, EAR, SIDE OF FACE).....	<input type="checkbox"/>	<input type="checkbox"/>	IF YES, DATE OF PLACEMENT.....		
DIFFICULTY IN OPENING OR CLOSING.....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS.....	<input type="checkbox"/>	<input type="checkbox"/>
DIFFICULTY IN CHEWING.....	<input type="checkbox"/>	<input type="checkbox"/>			
DO YOU HAVE FREQUENT HEADACHES.....	<input type="checkbox"/>	<input type="checkbox"/>			
DO YOU CLENCH OR GRIND YOUR TEETH.....	<input type="checkbox"/>	<input type="checkbox"/>			

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____
