

PATIENT REGISTRATION AND HEALTH HISTORY

MEDICAL ALERT:

*A warm welcome, in order to provide you with optimum dental care we require a thorough medical and dental history which is unique to you. Be assured that all information is kept strictly confidential. Please take a moment to answer each question on **BOTH** sides of this questionnaire.*

I. PERSONAL INFORMATION:

FULL NAME: _____ BIRTHDATE: _____ SOC.INS.# _____
DD MM YY

ADDRESS: _____
STREET CITY POSTAL CODE

TEL: HOME _____ WORK: _____ E-MAIL _____

INSURANCE CARRIER: _____ GROUP # _____ ID # _____ EMPLOYER: _____

BASIC: _____ % CROWN/BRIDGE: _____ % REM. PROS: _____ % ORTHO _____ %

NAME OF SPOUSE: _____ BIRTHDATE: _____

SECONDARY CARRIER: _____ GROUP # _____ ID # _____ EMPLOYER: _____

BASIC: _____ % CROWN/BRIDGE: _____ % REM.PROS: _____ % ORTHO _____ %

Whom may we thank for referring you to our office?: _____

II. MEDICAL HISTORY: (CONFIDENTIAL)

PHYSICIAN NAME: _____ PHYSICIAN PHONE: _____

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Are you in good health? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had a serious illness, operation, or hospitalization? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you now under the care of a physician for any ongoing treatment or therapy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. My last physical examination was on: _____ | | |
| 6. Are you now taking any medicine, drugs, or pills? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please list: _____ | | |
| 7. Do you have <u>any</u> allergies? If yes, to what? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have or have you had any of the following diseases or problems?
<small>(Please circle): Any Heart Disease, Artificial Heart Valve, High Blood Pressure, Asthma, Tuberculosis,
 Any Lung Disease, Hives or Skin Rash, Any Kidney trouble, Hepatitis, Jaundice, Any Liver Disease, Ulcers,
 Any Arthritis, Rheumatic Fever, Cancer, AIDS, Drug Addiction, Hemophilia, Mental or Nervous Disorder, Epilepsy.</small> | | |
| 9. Do you, or has any member of your family had diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you have any blood disorders or do you bleed excessively? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had injury, surgery, or X-ray therapy to face or jaws? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you have a tendency to faint? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you have frequent severe headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Are you on a special diet? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you have a prosthetic implant? (i.e. hip?) | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. WOMEN ONLY - Are you pregnant? (Which month: _____) | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Do you have any disease, condition, or problem not listed above that you think the
Dentist should know about? If yes, please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Date _____ Patient's Signature _____

NOTES: _____

PLEASE TURN OVER

III. DENTAL HISTORY:

A. What concerns you most about your dental health? _____

		YES	NO
B.	Do you see a dentist on a routine basis?	<input type="checkbox"/>	<input type="checkbox"/>
	i - Date of last dental visit? _____		
	ii - Date of last dental cleaning? _____		
	iii - Date of last full mouth series of X-rays? _____		
C.	Are you having pain at this time?	<input type="checkbox"/>	<input type="checkbox"/>
D.	Have you ever had:		
	i - Orthodontic treatment (Braces)? _____	<input type="checkbox"/>	<input type="checkbox"/>
	ii - Oral Surgery? _____	<input type="checkbox"/>	<input type="checkbox"/>
	iii - Periodontal treatment (Gum Surgery)? _____	<input type="checkbox"/>	<input type="checkbox"/>
	iv - Worn a bite guard or other appliance? _____	<input type="checkbox"/>	<input type="checkbox"/>
E.	Have you noticed any loosening of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
F.	Does food tend to become caught between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
G.	Do you suffer from pain and/or swelling of your gums?	<input type="checkbox"/>	<input type="checkbox"/>
H.	Do your gums often bleed when you brush your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
I.	Problems of the jaw. Have you experienced:		
	i - Clicking of the jaw?	<input type="checkbox"/>	<input type="checkbox"/>
	ii - Pain (joint, ear, side of face)?	<input type="checkbox"/>	<input type="checkbox"/>
	iii - Difficulty in opening or closing?	<input type="checkbox"/>	<input type="checkbox"/>
	iv - Difficulty in chewing?	<input type="checkbox"/>	<input type="checkbox"/>
J.	Habits. Do you:		
	i - Clench or grind your teeth while awake or asleep?	<input type="checkbox"/>	<input type="checkbox"/>
	ii - Bite your lips or cheeks regularly?	<input type="checkbox"/>	<input type="checkbox"/>
	iii - Hold foreign objects with your teeth (such as pencils, pipe, pins, nails, fingernails)	<input type="checkbox"/>	<input type="checkbox"/>
	iv - Mouth breathe while awake or asleep?	<input type="checkbox"/>	<input type="checkbox"/>
K.	Do you feel nervous about having dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
L.	Have you ever had an upsetting experience in a dental office?	<input type="checkbox"/>	<input type="checkbox"/>
M.	Is it important to keep your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
N.	Are you dissatisfied with the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
	If you could, what features of your smile would you like to change? _____		

O.	Is there anything else about having dental treatment that bothers you?	<input type="checkbox"/>	<input type="checkbox"/>
	Please explain: _____		

P. Insurance companies now only allow for "functionally acceptable work", whereas, in the past their coverage was for "quality work". It is our desire to provide our patients with the highest quality work within their financial capabilities and desires.

What is important to you? (check one)

- The highest quality dentistry available
- The most economical treatment plan
- Dentistry limited to insurance coverage
- A combination of the above, please explain: _____

Consent:

The undersigned hereby authorizes the Dentist to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Dentist to make a thorough diagnosis of the patient's dental needs. I also authorize the Dentist to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (name of Patient) _____ after discussion and consultation between the named patient (or guardian of) and the dentist including alternative options or the consequences of no treatment. I also understand the use of anesthetic agents embodies a certain risk.

 PATIENT (OR LEGAL GUARDIAN IF PATIENT IS UNDER THE AGE OF 18)

 DATE