PATIENT REGISTRATION AND HEALTH HISTORY

DATE_____

PATIENT'S NAME _____ **DATE OF BIRTH** _____
MINOR MARRIED SINGLE MALE FEMALE

IF COMPLETING THIS FORM FOR ANOTHER, YOUR RELATIONSHIP_____

SPOUSE, PARENT'S OR GUARDIAN'S NAME_____

ADDRESS _____**TOWN**_____**ZIP**_____

HOME PHONE (_____)_____ **BUSINESS PHONE (_____)**_____

CELLULAR PHONE # _____**E-MAIL ADDRESS** _____

WHAT IS YOUR OCCUPATION ? _____

BUSINESS NAME AND ADDRESS _____

PATIENT'S SOCIAL SECURITY NUMBER _____

PATIENT'S DRIVER LICENSE NUMBER & STATE_____

PERSON TO CONTACT IN CASE OF EMERGENCY _____
RELATIONSHIP TO PATIENT_____ **TELEPHONE #:(_____)**_____

DO YOU HAVE ANY DENTAL INSURANCE OR COVERAGE ? YES / NO

HAS YOUR DENTAL INSURANCE CHANGED SINCE LAST APPT.? YES / NO

IS PATIENT COVERED BY AN ADDITIONAL DENTAL INSURANCE YES / NO

INSURANCE INFO.	***PRIMARY INS. CO***	***ADDITIONAL / SECONDARY INS CO.***
EMPLOYEE NAME	_____	_____
EMPLOYEE SS # / ID #	_____	_____

SPOUSE'S EMPLOYER'S NAME AND ADDRESS _____

SPOUSE'S WORK TELEPHONE NUMBER (_____)_____

PERSON RESPONSIBLE FOR PAYMENT _____

NUMBER OF CHILDREN IN FAMILY _____ **AGES** _____

PAST MEDICAL / DENTAL HEALTH HISTORY

PHYSICIAN'S NAME AND ADDRESS_____

ARE YOU CURRENTLY UNDER HIS CARE _____ **IF SO FOR WHAT ?** _____

ANY CHANGE IN YOUR MEDICAL HISTORY IN THE PAST YEAR ? WHAT ?_____
PHYSICAL EXAMINATION DATE _____

DO YOU TAKE ASPIRIN DAILY ? YES / NO
IF SO, LAST DAY YOU TOOK ASPIRIN - _____

BLOOD PRESSURE _____ / _____

MEDICAL CONDITION: EXCELLENT GOOD FAIR POOR

NAME OF LAST DENTIST / TOWN _____

DATE OF LAST DENTAL EXAMINATION _____

PHARMACY NAME, LOCATION, TELEPHONE # _____

NAME OF ORAL SURGEON I HAVE USED _____
LOCATION _____

PLEASE INITIAL	YES	NO
ANY SERIOUS TROUBLE ASSICIATED WITH DENTAL TREATMENT	_____	_____
ANY PAIN OR DISCOMFORT (HOT, COLD, ETC.) IF SO, WHERE	_____	_____
DO YOU WEAR REMOVABLE DENTAL APPLIANCES	_____	_____
ANYTHING YOU DISLIKE ABOUT YOUR SMILE	_____	_____
DO YOU WANT TO WHITEN/BRIGHTEN YOUR SMILE	_____	_____
HOSPITALIZED EVER ?	_____	_____
IF SO, FOR WHAT ? _____		
ANY MEDICATION PRESENTLY	_____	_____
IF SO WHAT ? _____		
ALLERGY OR SENSITIVITIES TO ANY MEDICINES/ LATEX / FOODS	_____	_____
IF SO , WHAT ? _____		
SUBJECT TO PROLONGED BLEEDING	_____	_____
SLEEP WITH 2-3 PILLOWS	_____	_____
ANY PROBLEMS WITH ANESTHETICS	_____	_____
DO YOU HAVE A HEART MURMUR	_____	_____
DO YOU HAVE AN ARTIFICIAL JOINT	_____	_____
DO YOU HAVE DENTAL IMPLANTS	_____	_____
DO YOU HAVE NIGHT SWEATS OR LOSS OF WEIGHT ?	_____	_____
DO YOU HAVE ANY EATING DISORDERS	_____	_____
WHEN YOU WALK UP THE STAIRS, DO YOU HAVE TO STOP BECAUSE OF PAINS IN YOUR CHEST OR SHORTNESS OF BREATH ?	_____	_____
HAVE YOU USED DIET PILLS – FEN-PHEN / REDUX	_____	_____
DO YOU HAVE CARIOMYOPATHY (HEART FAILURE)	_____	_____

PLEASE CIRCLE ANY OF THE ILLNESS YOU HAVE HAD AND DATE

CONGESTIVE HEART FAILURE	MONONUCLEOSIS	MENINGITIS
HEART FAILURE	EMPHYSEMA	AIDS / HIV POSITIVE
HEART DISEASE OR ATTACK	INFECT. HEPATITIS	SERUM HEPATITIS
ANGINA PECTORIS	TUBERCULOSIS [TB]	COUGH PERSISTENT
HIGH BLOOD PRESSURE	ASTHMA	LIVER DISEASE
HEART MURMUR	MRSA	YELLOW JAUNDICE
RHEUMATIC FEVER	SINUS TROUBLE	BLOOD / TRANSFUSION
CONGENITAL HEART LESION	ALLERGIES/HIVES	DRUG ADDICTION
PREVIOUS ENDOCARDITIS	DIABETES	HEMOPHILIA
ARTIFICIAL HEART VALVE	THYROID DISEASE	V.D. / VENEREAL DISEASE
HEART PACEMAKER	RADIATION THERAPY	COLD SORES
HEART SURGERY	CHEMOTHERAPY	HEPATITIS A B C
ARTIFICIAL JOINT	ARTHRITIS	SEIZURES
BY-PASS SURGERY-HEART	DIARRHEA	UNKNOWN FEVER
MITRAL VALVE PROLAPSE	RHEUMATISM	FAINTING / DIZZY
STROKE	CORTISONE MEDICATION	NERVOUSNESS
KIDNEY TROUBLE	GLAUCOMA	PSYCHIATRIC TMT.
ULCERS	PAIN IN JOINTS	BRUISE EASILY
NOSE BLEEDS	ANKLE SWELLING	JAUNDICE
BLOOD TEST-RECENT	INSOMNIA	HEPATITIS - VIRAL
ARC-AIDS RELATED COMPLEX	ORAL FUNGUS	EPILEPSY
PROLONGED BLEEDING	FAINT OFTEN	ANEMIA
BIRTH CONTROL PILLS	LYME DISEASE	OSTEOPOROSIS
BRONCHITIS	PNEUMONIA	FOOD IMPACTION
MOBILE (LOOSE) TEETH	BLEEDING GUMS	PREGNANT # MO._____
LUPUS ERYTHEMATOSIS	DRY MOUTH	BREATH ODOR
LONG TERM USE OF BREATH MINTS	PAST PREMEDICATIONS	OTHER SERIOUS ILLNESS
SMOKE - CIGARETTES---PIPE---CIGARS	SWOLLEN NECK GLANDS	FEN-PHEN / REDUX
LATEX ALLERGY	SCARLET FEVER	OTHER_____

WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE_____

THE UNDERSIGNED AGREES THAT ALL THE STATEMENTS ON THIS FORM ARE CORRECT AND I WILL NOTIFY THE OFFICE OF ANY CHANGES.

SIGNATURE OF PATIENT OR GUARDIAN_____DATE:_____

REVIEWED BY DOCTOR_____