## REGISTRATION AND HEALTH HISTORY

Patient Information (please print):

Last Name_____ First Name_____ Middle Initial _____

Nickname _____ Patient's Date of Birth_____/_____/_____Age ____ ☐ Male ☐ Female

*If this appointment is for your child, your name _____

Patient's Address _____ City_____ State ____ Zip _____

Home Phone (____)_____-_____Work Phone (____)_____-_____ Cell Phone (____)_____-_____

Personal E-mail Address _____Work E-mail Address _____

Employed by _____ How long? _____Occupation _____

Marital Status (check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Last Name _____ First Name_____ Middle Initial _____

Spouse's Date of Birth _____/_____/_____ Social Security # _____-_____-_____Or ID_____

Home Phone (____)_____-_____Work Phone (____)_____-_____ Cell Phone (____)_____-_____

Personal E-mail Address _____Work E-mail Address _____

Employed by _____ How long? _____Occupation _____

## DENTAL INSURANCE INFORMATION

Please provide us with your insurance card to copy for your file.
We are happy to assist you in filing your insurance, however, you are responsible for your account balance.

Primary Insurance Information (please print)

Subscriber's Last Name _____ First Name_____ Middle Initial _____

Patient's Relationship to Subscriber (check one) ☐ Self ☐ Spouse ☐ Child ☐ Other

Subscriber's Social Security # _____-_____-_____ Subscriber's Date of Birth_____/_____/_____

Subscriber's Address_____ City_____ State ____ Zip _____

Name of Employer_____ Group#_____ ID # _____

Insurance Company & Mailing Address _____

City _____ State _____ Zip_____Phone (____)_____-_____

Secondary Insurance Information (please print)

Subscriber's Last Name _____ First Name_____ Middle Initial _____

Patient's Relationship to Subscriber (check one) ☐ Self ☐ Spouse ☐ Child ☐ Other

Subscriber's Social Security Number _____-_____-_____ Subscriber's Date of Birth _____/_____/_____

Subscriber's Address_____ City_____ State ____ Zip _____

Name of Employer_____ Group#_____ ID # _____

Insurance Company & Mailing Address _____

City _____ State _____ Zip_____Phone (____)_____-_____

## ACCOUNT INFORMATION

Person Financially Responsible for Account _____

Address_____ City_____ State ____ Zip _____

Home Phone (____)_____-_____Work Phone (____)_____-_____ Cell Phone (____)_____-_____

Emergency Contact Person _____

Home Phone (____)_____-_____Work Phone (____)_____-_____ Cell Phone (____)_____-_____

How did you hear about our office (referral)? ☐ Radio ☐ Internet ☐ Family/Friend ☐ YellowPages ☐ Dr. Referral

☐ Other _____

**(OVER)**

## DENTAL HISTORY

1. Who was your former dentist? Name _____
   City _____ State _____ Zip _____ Phone (____)_____-_____
2. When was your last dental treatment? _____/_____/_____ Type of Treatment _____
3. Are you having pain or discomfort at this time? ☐ YES ☐ NO Where? _____
4. How would you describe your present dental health? ☐ Good ☐ Fair ☐ Poor
5. Have you experienced any unfavorable reaction to any previous dental treatment (anesthetic reaction, pain, other)?
   _____
6. Are you satisfied with your tooth appearance? ..... ☐ YES ☐ NO
7. Are you satisfied with your tooth color? ..... ☐ YES ☐ NO
8. Do you feel your teeth are: ☐ crowded? ☐ poorly aligned? ☐ protruding?
9. Do you have fractures in your front teeth? ..... ☐ YES ☐ NO
10. Are you hiding your teeth while smiling? ..... ☐ YES ☐ NO

## MEDICAL HISTORY

1. Have you been a patient in the hospital during the past two years? ..... ☐ YES ☐ NO
2. Have you been under the care of a medical doctor during the past two years? ..... ☐ YES ☐ NO
3. Have you taken any medicine or drugs during the past two years? ..... ☐ YES ☐ NO
   If yes, please list _____
   _____
4. Do you take any of the following bisphosphantes such as? ☐ Fosamx ☐ Actonol ☐ Resclast ☐ Other _____
5. Are you aware of being allergic to any medications, latex, or substances? ..... ☐ YES ☐ NO
   If yes, please list _____
6. Check any of the following which you have had or have at present:

| | | |
|---|---|---|
| ☐ Heart Murmur | ☐ Anemia | ☐ Arthritis |
| ☐ Mitral Valve Prolapse | ☐ Blood Transfusion | ☐ Bruise Easily |
| ☐ Rheumatic Fever | ☐ Chemotherapy/Radiation | ☐ Epilepsy |
| ☐ Artificial Joints | ☐ Drug Addiction | ☐ Fainting |
| ☐ Heart Problems | ☐ Kidney Trouble | ☐ Glaucoma |
| ☐ High Blood Pressure | ☐ Pain in Jaw Joints | ☐ Headaches |
| ☐ Emphysema | ☐ Psychiatric Treatment | ☐ Liver Disease |
| ☐ Asthma | ☐ Tuberculosis | ☐ Seizures |
| ☐ Diabetes | • persistent cough | ☐ Sickle Cell Diseases |
| ☐ A.I.D.S. | • bloody sputum | ☐ Sinus Trouble |
| ☐ Hepatitis A (infectious) | • anorexia | ☐ Stroke |
| ☐ Hepatitis B (serum) | • fever | ☐ Veneral Disease |
| ☐ Hepatitis C | ☐ Thyroid Disease | |
| ☐ H.I.V. | ☐ Ulcers | |

FOR WOMEN ONLY:

Are you pregnant? ☐ YES ☐ NO If yes, what month? _____

Are you taking birth control pills? ☐ YES ☐ NO

7. Do you have any disease, condition or problems not listed? _____

**Consent:**

The undersigned acknowledges reading the Informed Consent form and hereby authorizes the Practice to take radiographs, photographs, or study models, and to use any other diagnostic aids deemed appropriate for accurate diagnosis of the patient's dental needs. I also authorize the Practice to perform any and all forms of treatment, medication and therapy that may be indicated. Further, I understand the responsibility of payment for dental services provided to my dependents and myself is due and payable at the time service is rendered. Having received and read the Practice Notice of Privacy, I authorize the use and disclosure of this information for the purposes of treatment, payment, dental care, and referral.

Patient _____ Date ____/____/_____

Parent/Responsible Party _____ Relationship to Patient _____