Health History & Registration

PATIENT

PATIENT'S NAME Last_____ First _____ MI___ Sex: M F Birth date_____ Age_____
Soc. Sec.# _____If Patient is a minor, give Parent or Guardian's name_____ Today's Date_____
Who may we thank for referring you to our office? _____ Reason for visit_____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First_____ MI ____Marital status_____
RESIDENCE Street _____ Apt#_____ City_____ State_____ Zip_____
MAILING ADDRESS Street_____ Apt#_____ City_____ State_____ Zip_____
HOW LONG AT THISS ADDRESS_____ Home Phone #_____ Cell Phone #_____
Work Phone#_____ E-Mail _____
Soc. Sec. # _____ Birth date_____ Drivers License #_____ Relation to patient_____
Employer_____ Occupation_____ No. yrs employed _____

RESPONSIBLE PARTY SPOUSE

NAME Last_____ First _____MI____ Birth date_____ Soc. Sec. # _____
Employer_____ Occupation _____No. yrs employed_____
Home Phone#_____ Cell Phone#_____ Work Phone#_____ E-Mail_____

EMERGENCY CONTACT NOT LIVING WITH YOU

Name_____ Relationship_____ Home Phone#_____
Address_____ City, State, Zip _____ Cell Phone #_____

DENTAL HISTORY			MEDICAL HISTORY			Please circle if you have or have had the following:		
Date of last full mouth X-Ray			Do you have any current health problems?	Y	N	AIDS	Circulatory	Stroke
Are you having problems now?	Y	N	Are you under the care of a physician?	Y	N	Anaphylaxis	Problems	Tonsillitis
What?			For what?			Anemia	Heart issues	Ulcer
Is your dental health poor?	Y	N	What medications are you taking?			Arthritis	Hemophilia	Tuberculosis
Do you have headaches, earaches or neck pains?	Y	N				Artificial joints	Kidney disease	Swelling
			Are you pregnant?	Y	N	Asthma	Liver disease	Diabetes
Do you wear dentures?	Y	N	Do you use cigarettes or chewing tobacco	Y	N	Atopic	Nervous problems	Epilepsy
Are you unhappy with your dentures?	Y	N				Back problems	Psychiatric care	Fainting
Would you like to know about permanent replacements?	Y	N	**Name of previous dentist:** **City:** **State:** **Family physician:** **Phone:** **E-Mail:**			Blood disease	Weight gain	Herpes
Are you apprehensive about dental treatment?	Y	N				Chemotherapy	Weight loss	Hepatitis
Have you had any periodontal (gum) treatments?	Y	N				Headaches	Radiation Tx	Jaw pain
Have you worn braces before?	Y	N				Cortisone Tx	Respiratory disease	Glaucoma
Do you regularly use floss?	Y	N				Cough	Scarlet fever	Allergies
						Cough blood	Shingles	Rash
						Food allergies	Short of breath	Cancer
							Thyroid disease	
						ARE YOU ALLERGIC OR HAVE YOU ACTED ADVERSELY TO ANY MEDICATIONS? ANY OTHER ALLERGIES?		

Patient Signature_____ Date_____ Dentist Signature_____