PATIENT NUMBER

PATIENT'S NAME _____
Last First Initial

IF CHILD:
PARENT'S NAME _____
Last First Initial

HOW DO YOU WISH TO BE ADDRESS _____

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor ☐

RESIDENCE - STREET _____

CITY _____ STATE _____ ZIP _____

BUSINESS ADDRESS _____

TELEPHONE: RES. _____ BUS. _____

PATIENT/PARENT EMPLOYED BY _____

PRESENT POSITION _____ HOW LONG HELD _____

SPOUSE/PARENT NAME _____

SPOUSE EMPLOYED BY _____

PRESENT POSITION _____ HOW LONG HELD _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT _____

METHOD OF PAYMENT: Check ☐ Credit Card ☐ Cash ☐

DRIVER'S LICENSE #: _____

STATE ISSUED: _____

PURPOSE OF CALL _____

OTHER FAMILY MEMBERS IN THIS PRACTICE _____

_____

WHOM MAY WE THANK FOR THIS REFERRAL _____

_____

PATIENT/PARENT SOCIAL SECURITY NO. _____

SPOUSE/PARENT SOCIAL SECURITY NO. _____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY NOT LIVING WITH YOU _____

_____

Date _____ Date of Birth _____

DENTAL INSURANCE 1ST COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____ # YRS. _____

NAME OF INSURANCE CO. _____

ADDRESS _____

_____

TELEPHONE: _____

PROGRAM OR POLICY # _____

UNION LOCAL OR GROUP _____

SOCIAL SECURITY NO. _____

DENTAL INSURANCE 2ND COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____ # YRS. _____

NAME OF INSURANCE CO. _____

ADDRESS _____

_____

TELEPHONE: _____

PROGRAM OR POLICY # _____

UNION LOCAL OR GROUP _____

SOCIAL SECURITY NO. _____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENTS OR GUARDIAN'S SIGNATURE _____ DATE _____

REGISTRATION

PATIENT NUMBER

PATIENT'S NAME _____
Last First Initial Date of Birth

1. Purpose of initial visit _____
2. Are you aware of a problem? _____
3. How long since your last dental visit? _____
4. What was done at that time? _____
5. Previous dentist's name _____
   Address: _____ Tel. (____) _____
6. When was the last time your teeth were cleaned? _____

CIRCLE THE APPROPRIATE ANSWER

7. Have you made regular visits? ..... YES NO
   How often? _____
8. Were dental x-rays taken? ..... YES NO
9. Have you lost any teeth or have any teeth been removed? ..... YES NO
   Why? _____
10. Have they been replaced? ..... YES NO
11. How have they been replaces?
    a. Fixed bridge _____ Age _____
    b. Removable bridge _____ Age _____
    c. Denture _____ Age _____
12. Are you happy with the replacement? ..... YES NO
    If no, explain _____
13. Would you like to know about permanent replacements? ..... YES NO
14. Have you ever had any problems or complications with previous dental treatment?.. YES NO
    If yes, explain _____
15. Do you clench or grind your teeth? ..... YES NO
16. Does your jaw click or pop? ..... YES NO
17. Have you experienced any pain or soreness in the muscles or your face or around your ear? ..... YES NO
18. Do you have frequent headaches, neckaches or shoulder aches? ..... YES NO
19. Does food get caught between your teeth? ..... YES NO
20. Are any of your teeth sensitive to hot _____ cold _____ sweets _____ pressure _____
21. Do your gums bleed or hurt? ..... YES NO
    When? _____
22. How often do you brush your teeth? _____ When ? _____
23. Do you use dental floss? ..... YES NO
    How often? _____
24. Are any of your teeth loose, tipped or shifted? ..... YES NO
25. Are you happy with the appearance of your teeth; do you have any discolored teeth that bother you? ..... YES NO
26. How do you feel about your teeth in general? _____
27. Do you feel your breath is offensive at times? ..... YES NO
28. Have you ever had gum treatment or surgery? ..... YES NO
    What _____
    Where _____
    When _____
29. Have you had any orthodontic work? ..... YES NO
30. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____
31. Do you have any questions or concerns? ..... YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

Form No. 150DH

DENTAL HISTORY

HEALTH HISTORY

Name _____ Date _____

Date of last health care exam: _____ What was this exam for? _____

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: _____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Heart Murmur (mitral valve prolapse)	No	Yes	Psychosis	No	Yes
Anemia	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Slow-Healing Mouth Sores	No	Yes
Hepatitis, Any Form	No	Yes	Other Infections	No	Yes
Rheumatic Fever	No	Yes	Recurrent Illnesses	No	Yes
Asthma	No	Yes	Joint Replacement	No	Yes
HIV Positive or AIDS Related Complex	No	Yes	Glaucoma	No	Yes
Emphysema or other Respiratory	No	Yes	Abnormal Bleeding from a cut	No	Yes
Illnesses	No	Yes	Liver Disease (including Jaundice)	No	Yes
Abnormal Heart Condition	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Kidney Disease	No	Yes	Latex Sensitivity	No	Yes
Heart (Surgery, Disease, Attack)	No	Yes	H.I.V. Infection/AIDS	No	Yes
Venereal Disease	No	Yes	Cancer	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagamet (Cimetidine)?	No	Yes
Antacids?	No	Yes	Herbal supplements?	No	Yes
Treated with I.V. Bisphosphate drugs?	No	Yes	Head and Neck Radiation?	No	Yes

Please list any medications you are currently taking:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Women: Are you pregnant? No Yes
If no, are you planning a pregnancy in the near future? No Yes
Are you a nursing mother? No Yes
Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle) No Yes
If yes, what is it usually: S /D

Are you allergic or have you had a reaction to:

a. Local anesthetics ..... No Yes
b. Penicillin or other antibiotics ..... No Yes
c. Aspirin ..... No Yes
d. Codeine, valium or other sedatives..... No Yes
e. Other _____

Are you a smoker? No Yes
If so, how much do you smoke per day? _____

Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes

Weight: _____

Diet: Restricted Diet _____
How many meals a day _____
Food Allergies _____
Sugar in your diet: ❑ None ❑ Slight ❑ Moderate ❑ High

DOCTOR'S USE ONLY
Comments on patient interview concerning medical history:

_____

_____

Significant findings from questionnaire or oral interview:

_____

_____

Dental management considerations:

_____

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

_____ _____ _____
Patient (Print Name) *Patient Signature* *Date*

_____ _____ _____
Doctor (Print Name) *Doctor Signature* *Date*

INFORMATION UPDATE

Have you had a change in your health since your last visit? No Yes

Heart (Surgery, Disease, Attack)	No	Yes	Hepatitis, Any Form	No	Yes
Heart Murmur (mitral valve prolapse)	No	Yes	Rheumatic Fever	No	Yes
Joint Replacement	No	Yes	H.I.V. Infection/AIDS	No	Yes
Taken Fen-phen or other diet pills	No	Yes			

Have you had a visit to a physician since your last dental visit? No Yes

Women: Are you pregnant? No Yes Are you a nursing mother? No Yes

Please list any medications you are currently taking:
1. _____ 3. _____
2. _____ 4. _____

Do you have any allergies? No Yes List: _____

Notes: _____

_____

_____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____