

REGISTRATION FORM / MEDICAL-DENTAL HISTORY

Name: _____ Date: _____
SSN: _____
Address: _____ Home Telephone: (____) _____
City: _____ State: _____ Zip Code: _____ Cell Phone: (____) _____
Date of Birth: _____ Marital Status: S M D W Spouse's Name: _____
Email Address: _____
Employer's Name: _____ Will you receive calls at work? YES NO
Occupation: _____ Business Phone: (____) _____
How would you prefer to be addressed? _____
Person Responsible for Fee (if other than patient): _____
Whom may we thank for referring you to this office? _____
Do we have permission to go over your treatment plan/accounts/dental records with family members?
YES NO If yes, who do we have permission to speak with? _____
Whom should we contact in case of emergency – Name & Telephone: _____

Name of Dental Insurance Company: _____
Subscriber's name & Relationship to Patient: _____
Subscriber's SSN: _____ Subscriber's Date of Birth: _____
Group Policy #: _____ Individual Policy #: _____

MEDICAL HISTORY

Please answer all the questions on this history form in pen and circle "yes" or "no" where applicable. The questions asked relate directly to the safe and effective treatment you are to receive. Please answer honestly to the best of your ability. If a question does not relate to you or your medical condition, please write "N/A" (not applicable) in the space provided.

All information you supply to the office on this form, the subsequent interview by the dentist and received from your physician or any other source will be held in the strictest confidence and will not be disclosed without your express and written permission.

- 1. Are you under a physician's care now? YES NO
If yes, please provide the name, address & telephone # of your physician:

- 2. Date of last visit to your physician: _____ Purpose of visit: _____
- 3. Has there been any change in your general health within the past year? YES NO
- 4. Have you had any serious illness, operation, or been hospitalized in the past 5 years? YES NO
- 5. Do you suffer from any disability? YES NO If yes, describe _____
- 6. Are you taking any drugs or medications? YES NO If yes, list and describe amounts and purpose: _____

7. Have you ever had an allergic reaction to medication? YES NO If yes, describe: _____

Note: *There are many drug and medication incompatibilities, some of which may result in dangerous health problems. Information about your current use of drugs and medication is essential.*

- 8. Have you lost or gained weight recently? YES NO If yes, please describe: _____
- 9. For females: Are you pregnant? YES NO If yes, when are you due? _____
- 10. For females: Are you taking birth control pills? YES NO
Note: There are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills.
- 11. Have you ever or do you now take illegal drugs? YES NO If yes, what drugs and when taken? _____

Note: *There are drugs and medication used in routine dental care that are incompatible with several illegal drugs. The effect of the combination maybe dangerous to your health and may be fatal.*

Please answer the following questions: (please circle)

- 12. Have you ever had heart surgery? YES NO If yes, when? _____
- 13. Do you have a pacemaker? YES NO If yes, when was it placed? _____
- 14. Have you undergone chemotherapy? YES NO If yes, please describe: _____
- 15. Have you ever had a major operation? YES NO If yes, please describe: _____

- 16. Have you ever had a serious injury to your head or neck? YES NO If yes, please describe: _____

- 17. Do you smoke? YES NO If yes, please describe type and quantity? _____
- 18. Are you on a special diet? YES NO If yes, for what reason and describe. _____
- 19. Have you been consulted or been treated by a psychiatrist, psychologist or counselor? YES NO
If yes, please describe: _____
- 20. Are there any other problems about your health of which you are aware? _____

Please answer if you or if you have a family history of the following listed medical conditions: (please circle)

- | | | | | | |
|----------------------------------|-----|----|-----------------------------|-----|----|
| 21. Abnormal/High blood pressure | YES | NO | 42. Frequent Cough | YES | NO |
| 22. AIDS or HIV+ | YES | NO | 43. Hay fever | YES | NO |
| 23. Alzheimer's | YES | NO | 44. Heart attack/failure | YES | NO |
| 24. Anemia | YES | NO | 45. Heart murmur | YES | NO |
| 25. Angina | YES | NO | 46. Hepatitis | YES | NO |
| 26. Artificial Heart Valve | YES | NO | If yes, which kind: A B C | | |
| 27. Artificial Joint | YES | NO | 47. Intestinal disease | YES | NO |
| 28. Arthritis/Rheumatism | YES | NO | 48. Irregular beats | YES | NO |
| 29. Asthma | YES | NO | 49. Kidney problems | YES | NO |
| 30. Blood disease | YES | NO | 50. Lung disease | YES | NO |
| 31. Breathing problems | YES | NO | 51. Obesity | YES | NO |
| 32. Cancer/Tumors | YES | NO | 52. Osteoporosis | YES | NO |
| 33. Cold Sores/Fever Blisters | YES | NO | 53. Renal dialysis | YES | NO |
| 34. Congenital heart disease | YES | NO | 54. Rheumatic fever | YES | NO |
| 35. Convulsions | YES | NO | 55. Rheumatic heart disease | YES | NO |
| 36. Colorectal Cancer | YES | NO | 56. Sleep apnea | YES | NO |
| 37. Diabetes | YES | NO | 57. Stroke | YES | NO |
| 38. Emphysema | YES | NO | 58. Stomach disease | YES | NO |
| 39. Epilepsy or Seizures | YES | NO | 59. Tuberculosis | YES | NO |
| 40. Excessive bleeding | YES | NO | 60. Venereal Disease | YES | NO |
| 41. Fainting spells/Dizziness | YES | NO | If yes, describe: _____ | | |

DENTAL HISTORY

Date of your last visit to a dentist: _____

Reason for your last visit (or series of visits): _____

Name of previous dentist: _____

In respect to any previous dental treatment, have you: (please circle)

- 61. Ever fainted? YES NO
- 62. Had an allergic reaction? YES NO If yes, please describe: _____
- 63. Had abnormal bleeding? YES NO
- 64. Been told by a physician to pre-medicate prior to dental treatment? YES NO
- 65. Any other complication during or following dental treatment? YES NO If yes, please describe: _____

NOTE: A change in your health status should be reported to the office at the earliest possible time.

To the best of my knowledge, the forgoing questions have been accurately answered.

Permission To Release Health Information

I grant the right to the dentist and dental staff to release health information obtained from me and information about my dental treatment to third party payers and/or other health practitioners.

Signature: _____ Date: _____

I, _____, have received a copy of this office's Notice of Privacy Practices and the Material Fact Sheet as required by law.

Signature: _____ Date: _____