REGISTRATION HISTORY

Date Called____________________

Appointed Day/Time____________________

Purpose of Call____________________

MS
MR
MISS
MRS ____________________ BIRTHDATE____________________
CHILD
*(PERSON RESPONSIBLE FOR ACCOUNT)*____________________

____

ADDRESS____________________

PHONE: HOME:____________ BUS:____________ CELL:____________

Pharmacy Name and Telephone #

____

DO YOU HAVE, HAVE YOU EVER HAD OR ARE YOU TAKING:

	YES	NO
ANTICOAGULANTS	___	___
HEART MURMUR	___	___
HEART DISEASE	___	___
MITRAL VALVE PROLAPSE	___	___
RHEUMATIC FEVER	___	___
ARTIFICIAL JOINTS	___	___
(*WOMEN*) PREGNANT	___	___

*PHYSICIANS NAME*____________________

*ADDRESS*____________________

____

*PHONE#*____________ *FAX#*____________

ARE YOU RECEIVING MEDICAL CARE/MEDICATION?, EXPLAIN____________________

____

WHEN WAS YOUR LAST DENTAL EXAM & X-RAYS TAKEN?____________________

PREVIOUS DENTIST NAME____________________

PHONE #____________________

DO YOU HAVE DENTAL INSURANCE? *YES*___ *NO*___ *SSN #*____________

WHOM MAY WE THANK FOR REFERRING YOU?____________________

(OFFICE USE)

DATE/TYPE OF X-RAYS TAKEN____________________

DATE & PERSON YOU SPOKE WITH____________________

*MED REQUIREMENT LETTER SENT*__________ *W/LETTER SENT*__________ *T/LETTER SENT*__________

NOTES:

PATIENT SOCIAL SECURITY NO. ______________________
PATIENT EMPLOYED BY______________________
BUSINESS ADDRESS______________________
PRESENT POSITIION______________________
IF YOU HAVE DENTAL INSURANCE, NAME OF INSURANCE COMPANY______________________
______________________ POLICY NO. ______________________

IF YOUR SPOUSE HAS DENTAL INSURANCE THAT COVERS YOU, NAME OF COMPANY______________________
______________________ POLICY NO. ______________________

SPOUSES NAME______________________

SPOUSES DATE OF BIRTH______________ SPOUSES SOCIAL SECURITY#______________
SPOUSE EMPLOYED BY______________________ PHONE NO.______________
BUSINESS ADDRESS______________________
PRESENT POSITION______________________

DENTAL HISTORY

DO YOU HAVE OR HAVE YOU HAD THE FOLLOWING:

	YES	NO		YES	NO
BLEEDING, SORE GUMS	___	___	CLENCHING/GRINDING	___	___
UNPLEASANT TASTE/BAD BREATH	___	___	SENSITIVE TO HOT/COLD	___	___
BURNING TONGUE/LIPS	___	___	SENSITIVE TO SWEETS	___	___
SWELLING/LUMPS IN MOUTH	___	___	SENSITIVE TO BITING	___	___
ORTHODONTIC TREATMENT	___	___	FOOD IMPACTION	___	___
CLICKING/POPPING OF JAW	___	___	CHANGE IN BITE	___	___
DIFFICULTY OPENING/CLOSING JAW	___	___	SHIFTING/LOOSE TEETH	___	___
PERIODONTAL SURGERY	___	___	HEADACHES	___	___

IS THERE ANY CONDITION OR PROBLEM THAT YOU THINK WE SHOULD KNOW ABOUT?
IF SO, EXPLAIN:______________________
____
____

MEDICAL HISTORY

ARE YOU IN GOOD HEALTH NOW? YES______ NO______

WHEN WAS YOUR LAST COMPLETE MEDICAL EXAM?______________________

HAVE YOU BEEN HOSPITALIZED IN THE LAST 5 YEARS? IF YES, REASON:
____

ARE YOU TAKING ANY MEDICATION? IF YES, REASON:
____
NAME OF MEDICATION AND DOSAGE:
____

CHILDREN: ARE ALL IMMUNIZATIONS CURRENT? YES________ NO__________

NAME OF PHYSICIAN____

ADDRESS____

PHONE#________________________ FAX#__________________

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED?

______________________________________ ***PHONE #:***______________

ARE YOU ALLERGIC TO:

	YES	NO
PENICILLIN	___	___
ERYTHROMYCIN	___	___
TETRACYCLINE	___	___
DENTAL ANESTHETICS	___	___
CLEOCIN/CLINDAMYCIN	___	___
ASPIRIN	___	___
CODEINE	___	___
SULFA DRUGS	___	___
LATEX GLOVES	___	___

OTHER MEDICATIONS OR DRUGS

____

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:

	YES	NO
ANTICOAGULANTS	___	___
GLAUCOMA	___	___
DRUG ADDICTION	___	___
LYME DISEASE	___	___
STROKE	___	___
CONVULSIONS/EPILEPSY	___	___
FAINTING/DIZZINESS	___	___
PSYCHIATRIC CARE	___	___
TUBERCULOSIS	___	___
ASTHMA	___	___
THYROID CONDITION	___	___
DIABETES	___	___
RHEUMATIC FEVER	___	___
HEART DISEASE	___	___
H I V POSITIVE	___	___
BLOOD PRESSURE LOW	___	___
BLOOD PRESSURE HIGH	___	___
ARTIFICIAL HEART VALVE	___	___
MITRAL VALVE PROLAPSE	___	___
HEART MURMUR	___	___

	YES	NO
EXCESSIVE BLEEDING/CUT	___	___
CANCER	___	___
PACEMAKER	___	___
ARTIFICIAL JOINTS	___	___
ARTHRITIS	___	___
HEPATITIS	___	___
JAUNDICE	___	___
ULCERS/ACID REFLUX DISEASE	___	___
HERPES	___	___
VENEREAL DISEASE	___	___
ANEMIA	___	___
BLOOD DISORDER	___	___
BLOOD TRANSFUSION	___	___
RADIATION THERAPY	___	___
TUMORS/GROWTHS/MALIGNANCIES	___	___
WOMEN: ARE YOU?		
PREGNANT	___	___
NURSING	___	___
ON HORMONAL THERAPY	___	___
ON BIRTH CONTROL PILLS	___	___

IS THERE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ON THIS FORM, THAT YOU THINK WE SHOULD KNOW ABOUT? IF SO, EXPLAIN:______________________________

____

____

CERTIFICATION: I CERTIFY THAT THE ANSWERS TO THE HEALTH QUESTIONS ARE CORRECT TO THE BEST OF MY KNOWLEDGE. IF I HAVE ANY CHANGE IN MY HEALTH OR IN MY MEDICATION, I WILL INFORM MY DENTIST AT MY NEXT VISIT.

*SIGNATURE OF PATIENT, PARENT OR GUARDIAN*____ *DATE*________________

FOR OFFICE USE ONLY____

MEDICAL UPDATE

DATE	MEDICAL CHANGES	STAFF INITIALS	PATIENT INITIALS