PATIENT REGISTRATION
AND
MEDICAL/DENTAL HISTORY

Medical Alert

Pharmacy Name_____ Phone_____

So that we may provide you with the best possible care, please complete both sides of this medical/dental history form.
(PLEASE PRINT)

Date_____

Home Phone_____ Work Phone_____ Cell/Pager _____ Email _____

Patient Name_____

Address_____

City_____ State_____ Zip_____ Social Security #_____ Driver's Lic.#_____

Sex: Male Female Age_____ Birthday ___/___/___ Single Married Widowed Separated Divorced

Employed By_____

Occupation_____

Business Address_____

City_____ State_____ Zip_____ Tel._____

Spouse Name_____ Birthday ___/___/___

Employed By_____

Business Address_____

City_____ State_____ Zip_____ Tel._____

Social Security #_____

Person Responsible For Account

Name: _____ Relation:_____

Billing Address: _____

_____

Hm# ( )_____ DL#_____

Employer: _____

Wk# ( )_____ Ext:_____ SS#_____

Dental Insurance Primary Carrier

Insured's Name Social Security #

Insurance Company Telephone

Address

City State Zip

Group Number ID Number Birthdate

Insured's Employer

Dental Insurance Secondary Carrier

Insured's Name Social Security #

Insurance Company Telephone

Address

City State Zip

Group Number ID Number Birthdate

Insured's Employer

In case of emergency, who should be notified?_____ Tel._____

Whom may we thank for referring you?_____

Medical History

Physician's Name_____ Date of Last Physical_____

Address_____ Tel._____

Please check the box of any condition you may have had.

- ❑ A.I.D.S./ HIV Positive or Other
- ❑ Allergies to Anesthetics
- ❑ Allergy to Colored Dyes
- ❑ Allergy to Latex
- ❑ Angina Pectoris
- ❑ Arthritis/Rheumatism
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Aspirin Taken Daily
- ❑ Asthma
- ❑ Back Problems
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Cancer, Leukemia
- ❑ Chemical Dependency
- ❑ Chemotherapy/Radiation Therapy
- ❑ Chronic Diarrhea
- ❑ Circulatory Problems
- ❑ Contact Lenses
- ❑ Diabetes
- ❑ Epilepsy/Seizures
- ❑ General Allergies* (List Below)
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Disease or Attack
- ❑ Heart Murmur
- ❑ Heart Pacemaker
- ❑ Hemophilia
- ❑ Hepatitis, Jaundice or Liver Disease
- ❑ High Blood Pressure
- ❑ Hypoglycemia
- ❑ Kidney Problem
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Nervous Problems
- ❑ Premedicate
- ❑ Psychiatric Care
- ❑ Recent Weight Loss
- ❑ Respiratory Problem
- ❑ Rheumatic Fever
- ❑ Sinus Problems
- ❑ Special Diet
- ❑ Stroke
- ❑ Swollen Neck Glands
- ❑ Thyroid Disease
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Venereal Disease
- ❑ Other* (List below)

*General Allergies:_____

*Other:_____

Patient Name _____

DENTAL HISTORY

What is the reason for your visit today? _____

_____

Is there anything about having dental treatment that you would like us to know? ❑ Yes ❑ No

If yes, please describe _____

_____

_____

Date of Last: **Dental Visit** _____ **Dental Cleaning** _____ **Full Mouth X-ray** _____ **Bitewing X-rays** _____

What treatment was done at your last dental visit? _____

_____

Previous Dentist's Name _____ Telephone _____

Address _____

City _____ State _____ Zip Code _____

How often do you have dental examinations? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? ❑ Yes ❑ No If yes, please describe: _____

Circle "Yes" or "No" to each item.

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No
How much? _____		

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If yes, please describe, including cause.

_____

Are any of your teeth sensitive to:

Hot or cold	Yes	No
Sweet	Yes	No
Biting or chewing	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or a change in your bite?	Yes	No
Do you have difficulty in chewing on either side of the mouth?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where? _____

_____

Have you ever experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (necks, shoulders)?	Yes	No
Are you happy with your smile?	Yes	No
Are you pleased with the color of your teeth?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If yes, what is your biggest concern?

_____

_____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe _____

_____

Do you have any drug allergies or have you ever had an adverse reaction to any medication or substance? ❑ Yes ❑ No

If yes, list _____

Have you ever responded adversely to medical or dental treatment? ❑ Yes ❑ No

Have you ever been advised to be pre-medicated prior to any dental treatment? ❑ Yes ❑ No

Are you taking any medication at this time? ❑ Yes ❑ No If yes, what _____

Have you ever taken Phen-Fen? Or Redux? ❑ Yes ❑ No If so, have you seen a cardiologist for a consult since taking it? ❑ Yes ❑ No

Are you under the care of a physician? ❑ Yes ❑ No If yes, for what condition _____

If Patient is a child what is his/her weight? _____

Have you had a recent transfusion? ❑ Yes ❑ No

Is there anything else we should know about your medical history _____

Women — Are you: Pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

I verbally reviewed the medical / dental information above with the parent / guardian & patient named herein.

_____
Staff /Dr.'s Initials Date

AUTHORIZATION AND RELEASE

The above information is accurate and complete to the best of my knowledge and is only for use in treatment, billing and processing of insurance for benefits for which I am entitled. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care, to third party payers and/or other health practitioners.

I authorize my insurance company to pay directly to the dental office the benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependents.

_____
Signature of Patient or Parent of Minor Date