DENTAL HEALTH HISTORY

Confidential

Patient Name_____ Birthdate_____
Last First Middle Initial

DENTAL HISTORY

Check (✓) if you have had problems with any of the following:

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss?_____ How often do your brush?_____

MEDICAL HISTORY

Physician's Name_____ Date of Last Visit_____

Have you had any serious illnesses or operations?_____ if yes, describe_____

_____

_____

Have you ever been told to take antibiotics before a dental procedure? ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have/had any of the following:

- ☐ Acid Relux/GERD
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Snoring/Sleep Apnea
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS

List medications you are currently taking:_____

_____

_____

_____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex _____
- ☐ Other _____

SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please Print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

If this appt is for you start here

DATE	ADULT
NAME	
SPOUSE	
ADDRESS	
CITY	STATE ZIP
PHONE NO.	CELL PHONE NO.
BIRTHDATE	AGE
EMAIL	
MARRIED / SINGLE / DIVORCED / WIDOWED	
SOCIAL SECURITY NO.	

If this appt is for your child start here

DATE	CHILD
NAME	
ADDRESS	
CITY	STATE ZIP
PHONE NO.	
BIRTHDATE	

GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?
THEIR NAME:
REFERRED TO US BY:

DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE COMPANY
EMPLOYEE
SS# or ID#
GROUP NO
DATE OF BIRTH
INS PHONE #
INSURANCE ADDRESS
CITY STATE ZIP

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT
NAME
DRIVERS LICENSE NO.
RELATIONSHIP TO PATIENT
SPOUSE
OCCUPATION
EMPLOYER
BUSINESS ADDRESS
BUSINESS PHONE

PERSON TO CONTACT FOR EMERGENCY
PHONE NUMBER
ADDRESS
CITY STATE ZIP

PLEASE FILL OUT REVERSE SIDE