# DENTAL HEALTH HISTORY

Confidential

Today's Date: _____

Patient Name: _____ Birthdate: _____
Last First Initial

## DENTAL HISTORY

Reason for Today's Visit _____ Date of Last Dental Care _____

Former Dentist _____ Date of Last Dental X-rays _____

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 you brush? _____

## MEDICAL HISTORY

Physician's Name _____ Phone: _____ Date of last visit _____

Have you had any serious illnesses or operations? _____ If yes, describe _____

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

Check ( ✔ ) if you have or have had any of the following:

- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Cortisone Treatments
- ❑ Cough, Persistent
- ❑ Cough up blood
- ❑ 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
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Skin Rash
- ❑ Stroke
- ❑ Swellingof feet or ankles
- ❑ Thyroid Problems
- ❑ Tobacco Habit
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Venereal Disease

## MEDICATIONS

List medications you are currently taking. _____

Preferred Pharmacy: _____

## ALLERGIES

- ❑ Aspirin
- ❑ Barbiturates (sleeping pills)
- ❑ Codeine
- ❑ Local Anesthetic
- ❑ Food _____
- ❑ Penicillin
- ❑ Sulfa
- ❑ Latex
- ❑ Other

## SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand 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

| DATE | ADULT |
|---|---|
| NAME | |
| SPOUSE | |
| MAILING ADDRESS | |
| CITY STATE ZIP | |
| PHONE NO. | TEXT? Y/N |
| BIRTHDATE | AGE |
| EMAIL | |

| MARRIED | SINGLE | DIVORCED | WIDOWED |
|---|---|---|---|

| SOCIAL SECURITY NO. |
|---|

## FOR CHILD APPT.

| NAME |
|---|
| ADDRESS |
| CITY STATE ZIP |
| PHONE NO. |
| BIRTHDATE |

## GETTING TO KNOW YOU

| EMERGENCY CONTACT |
|---|
| PHONE NO. |
| HOW DID YOU HEAR ABOUT US? FACEBOOK / GOOGLE / INSURANCE / FRIEND_____ OTHER _____ |

## DENTAL INSURANCE

| PRIMARY CARRIER |
|---|
| INSURANCE COMPANY |
| EMPLOYEE |
| SS# OR ID# |
| GROUP NO. |
| DATE OF BIRTH |
| INS. PHONE NO. |
| INSURANCE ADDRESS |

| CITY | STATE | ZIP |
|---|---|---|

## ACCOUNT INFORMATION

| PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT |
|---|
| NAME |
| DRIVERS LICENSE NO. |
| |
| |
| OCCUPATION |
| EMPLOYER |
| BUSINESS ADDRESS |
| BUSINESS PHONE NO. |

PLEASE FILL OUT REVERSE SIDE