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Patient Registration and Health History

Patient Name:_____
Last First MI Preferred Name

Address: _____
Street City State Zip Code

Title:____Gender:_____Male_____Female Family Status:_____Married____Single____Child____Other

Birth Date: _____ SS#: _____ Email: _____

Phone: _____ _____ _____
Home Cell Work

Best way to reach you? ____Home ____Cell ____E-mail ____Texting ____Work.

Employment Information

The following is for: ____ Patient ____ Person responsible for payment

Employer Name: _____

Address: _____
Street City State Zip Code

How did you hear about our office? _____

Person to contact in case of emergency? _____
Name Phone

Insurance Information

Name of Insured: _____

Insured's Birth Date: _____ ID#: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Employer Address: _____
Street City State Zip Code

Patient's Relationship to Insured: _____Self _____ Spouse _____ Child _____ Other

Insurance Plan Name: _____

Insurance Address: _____
Street City State Zip Code

Medical/Dental Questionnaire

On a scale of **1 - 10**, how important is it to keep your natural teeth for a lifetime? _____

Fill in the circle where you feel most accurately reflects your overall dental health

(Today) (Want to be 5 years from now.)

0___0___0___0___0___0___0___0___0___0___0 0___0___0___0___0___0___0___0___0___0___0

Poor Average Excellent Poor Average Excellent

Do your gums bleed when brushing or flossing? _____ Do you have a bad taste or bad breath? _____

Do you like the way your teeth look and feel? What would you change? _____

_____

Who is your Physician? _____

Name Address

Have you been under the care of a medical doctor during the past two years? _____

If yes, for what reason? _____

Are you taking medicine or drugs? ____yes ____ no

If yes, please list all medications.

_____

Are you allergic to penicillin? (i.e. itching, rash, swelling of hands, feet or eyes?) ____ yes ____ no

Any other allergies? _____

Are you a smoker? ____ yes ____ no Women: Are you pregnant? ____ yes ____ no

Please check any of the following which you have had or have at present:

__ Allergies	__ Anemia	__ Arthritis
__ Artificial Joints	__ Asthma	__ Blood Disease
__ Blood Thinner	__ Cancer	__ Diabetes
__ Dizziness	__ Epilepsy	__ Excessive Bleeding
__ Fainting	__ Glaucoma	__ Growths
__ Hay Fever	__ Head Injury	__ Heart Disease
__ Heart Murmur	__ Hepatitis	__ High Blood Pressure
__ HIV	__ Kidney Disease	__ Liver Disease
__ Mental Disorders	__ MVP	__ Nervous Disorders
__ Pacemaker	__ Radiation Treatment	__ Respiratory Problems
__ Rheumatic Fever	__ Sinus Problems	__ Stomach Problems
__ Stroke	__ Sulfa Allergy	__ Tuberculosis
__ Tumors	__ Ulcers	__ Venereal Disease

__ Any other conditions not listed _____

_____

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I have any change in my health, I will inform the doctor at the next appointment without fail.

I hereby authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that prior to treatment, full explanation of the procedure (s) involved will be given by the doctor and/or staff. I agree to pay for all services rendered by this office.

Signature: _____ Date: _____