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 _____

Email _____ Mobile Phone _____

Patient Name_____
Last First Initial Name Called By

Adress_____

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

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

Employed By_____ Occupation _____

Business Address_____

City_____ State _____ Zip_____ Tel. _____

Spouse/Partner Name _____ Birthday _____/____/_____ Employed By_____

Business Address_____

City_____ State_____ Zip_____ Social Security #_____

Who is responsible for this account?_____ Relationship to Patient _____

Dental Insurance Primary Carrier

_____
Insured's Name Social Sec. #

_____
Insurance Company

_____
Address

_____
City State Zip

_____
Group Number ID # Birthday

_____
Insured's Employer

Dental Insurance Secondary Carrier

_____
Insured's Name Social Sec. #

_____
Insurance Company

_____
Address

_____
City State Zip

_____
Group Number ID # Birthday

_____
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 ANY condition that you may have had

Heart Disease or Attack	Hepatitis/Jaundice/Liver Disease	Artificial Heart Valve	AIDS/HIV or Other	Special Diet
Heart Murmur	Epilepsy/Seizures	Artificial Joints	Tuberculosis	Swollen Neck Glands
Heart Pacemaker	Stroke	Recent Weight Loss	Respiratory Problems	Rheumatic Fever
Angina Pectoris	Headaches	General Allergies	Kidney Problems	Sinus Problems
Mitral Valve Prolapse	Cancer/Leukemia	Blood Disease	Thyroid Disease	Ulcer
High Blood Pressure	Chronic Diarrhea	Back Problems	Glaucoma	Venereal Disease
Low Blood Pressure	Allergies to Anesthetics	Nervous Problems	Diabetes	Chemical Dependency
Circulatory Problems	Contact Lenses	Psychiatric Care	Arthritis/Rheumatism	Hemophilia
Asthma	Hypoglycemia	Allergy to Latex	Allergy to Colored Dyes	Blood Transfusion

_____ _____
Signature of Patient or Guardian of Minor Date

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? No Yes

If yes, please describe_____

_____

_____

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

What treatment was done at your last dental visit?_____

_____

Previous Dentist's Name_____Tel_____

Address_____

City_____ State_____ Zip_____ 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? No Yes

Please Describe: _____

_____

Please check ANY that Apply

Do You:

Clench or grind your teeth while awake or asleep?

Bite your lips or cheek regularly?

Hold foreign objects with your teeth? (pencil/pipes/etc)

Mouth breathe while awake or asleep?

Have tired jaws, especially in the morning?

Smoke/Chew tobacco?

How Much? _____

Have you ever had:

Orthodontic treatment?

Oral Surgery?

Periodontal Treatment?

Your teeth ground or the bite adjusted?

A bite plate or mouth guard?

A serious injury to the mouth or head?

If yes, please describe:

_____

_____

Are any of your teeth sensitive to:

Hot or Cold?

Sweet?

Biting or Chewing?

Have you noticed any mouth odors or bad taste?

Do you frequently get cold sores, blisters, or any other oral lesions?

Do your gums bleed or hurt?

Have your parents experienced gum disease or tooth loss?

Have you noticed any loose teeth or change in your bite?

Do you have any difficulty chewing on either side of the mouth?

Does food tend to become caught in between your teeth?

If Yes, Where?

_____

_____

Have you ever experienced:

Clicking or popping of the jaw?

Pain? (joint/ear/side of face)

Difficulty in opening or closing the mouth?

Headaches/Neckaches/Shoulder ache?

Sore muscles (neck/shoulders)?

Are you satisfied with your teeth's appearance?

Would you like to keep all of your teeth all of your life?

Do you feel nervous about having dental treatments?

If yes, what is your biggest concern?_____

_____

Have you ever had an upsetting dental experience?

If yes, please describe:

_____

_____

Do you have any drug allergies or have you ever had an adverse reaction to any medication or substances? NoYes

Are you taking any medications at this time? NoIf so, what?_____Yes

Are you under the care of a physician? NoFor what condition?_____Yes

If patient is a child, what is his/her weight? _____

WOMEN- Are you: None of theseTaking Birth Control?Nursing?Pregnant?

Have you had a recent transfusion? NoYes

Is there anything else we should know?_____

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 such dental care, to third party payers and or health practitioners.

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

I understand hat 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 my behalf or my dependents.

_____ _____

Signature of Patient or Guardian of Minor Date