REGISTRATION FORM / MEDICAL-DENTAL HISTORY

Date: _____

Name: _____ SSN: _____

Address: _____ Home Telephone: (____) _____

City: _____ State: _____ Zip Code: _____ Cell Phone: (____) _____

Date of Birth: _____ Marital Status: S M D W Spouse's Name: _____

Email Address: _____

Employer's Name: _____ Will you receive calls at work? YES NO

Occupation: _____ Business Phone: (____) _____

How would you prefer to be addressed? _____

Person Responsible for Fee (if other than patient): _____

Whom may we thank for referring you to this office? _____

Do we have permission to go over your treatment plan/accounts/dental records with family members?

YES NO If yes, who do we have permission to speak with? _____

Whom should we contact in case of emergency – Name & Telephone: _____

_____

Name of Dental Insurance Company: _____
Subscriber's name & Relationship to Patient: _____
Subscriber's SSN: _____ Subscriber's Date of Birth: _____
Group Policy #: _____ Individual Policy #: _____

MEDICAL HISTORY

Please answer all the questions on this history form in pen and circle "yes" or "no" where applicable. The questions asked relate directly to the safe and effective treatment you are to receive. Please answer honestly to the best of your ability. If a question does not relate to you or your medical condition, please write "N/A" (not applicable) in the space provided.

All information you supply to the office on this form, the subsequent interview by the dentist and received from your physician or any other source will be held in the strictest confidence and will not be disclosed without your express and written permission.

1. Are you under a physician's care now? YES NO
   If yes, please provide the name, address & telephone # of your physician:
   _____
   _____
   _____
2. Date of last visit to your physician: _____ Purpose of visit: _____
3. Has there been any change in your general health within the past year? YES NO
4. Have you had any serious illness, operation, or been hospitalized in the past 5 years? YES NO
5. Do you suffer from any disability? YES NO If yes, describe _____
6. Are you taking any drugs or medications? YES NO If yes, list and describe amounts and purpose:

_____
_____

7. Have you ever had an allergic reaction to medication? YES NO If yes, describe: _____

_____

***Note**: There are many drug and medication incompatibilities, some of which may result in dangerous health problems. Information about your current use of drugs and medication is essential.*

8. Please provide any additional known allergies: _____
9. Have you lost or gained weight recently? YES NO If yes, please describe: _____
10. For females: Are you pregnant? YES NO If yes, when are you due? _____
11. For females: Are you taking birth control pills? YES NO

***Note**: There are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills.*

12. Have you ever or do you now take illegal drugs? YES NO If yes, what drugs and when taken?

_____

***Note**: There are drugs and medication used in routine dental care that are incompatible with several illegal drugs. The effect of the combination maybe dangerous to your health and may be fatal.*

Please answer the following questions: (please circle)

13. Have you ever had heart surgery? YES NO If yes, when? _____
14. Do you have a pacemaker? YES NO If yes, when was it placed? _____
15. Have you undergone chemotherapy? YES NO If yes, please describe: _____
16. Have you ever had a major operation? YES NO If yes, please describe: _____

_____

17. Have you ever had a serious injury to your head or neck? YES NO If yes, please describe: _____

_____

18. Do you smoke? YES NO If yes, please describe type and quantity? _____
19. Are you on a special diet? YES NO If yes, for what reason and describe. _____
20. Have you been consulted or been treated by a psychiatrist, psychologist or counselor? YES NO
    If yes, please describe: _____
21. Do you have difficulty breathing through your nose and/or do you frequently snore? YES NO
22. Do you have difficulty falling asleep or staying asleep at night? YES NO
23. Have you ever been told you stop breathing while you were asleep? YES NO
    a. If yes, have you ever had a sleep study? YES NO
    b. If yes, were you diagnosed with a sleep-related breathing disorder (apnea)? YES NO
    c. If yes, were you prescribed a C-PAP to manage your sleep-related breathing disorder? YES NO
    d. If yes, do you wear your C-PAP as prescribed? YES NO
    e. If you do not wear your C-PAP as prescribed, please explain your reason(s): _____

    _____

    _____
24. Are there any other problems about your health of which you are aware? _____

Please answer if you or if you have a family history of the following listed medical conditions: (please circle)

25. Abnormal/High blood pressure	YES	NO	46. Frequent Cough	YES	NO
26. AIDS or HIV+	YES	NO	47. Hay fever	YES	NO
27. Ahlzeimer's	YES	NO	48. Heart attack/failure	YES	NO
28. Anemia	YES	NO	49. Heart murmur	YES	NO
29. Angina	YES	NO	50. Hepatitis	YES	NO
30. Artificial Heart Valve	YES	NO	If yes, which kind: A B C		
31. Artificial Joint	YES	NO	51. Intestinal disease	YES	NO
32. Arthritis/Rheumatism	YES	NO	52. Irregular beats	YES	NO
33. Asthma	YES	NO	53. Kidney problems	YES	NO
34. Blood disease	YES	NO	54. Lung disease	YES	NO
35. Breathing problems	YES	NO	55. Obesity	YES	NO
36. Cancer/Tumors	YES	NO	56. Osteoporosis	YES	NO
37. Cold Sores/Fever Blisters	YES	NO	57. Renal dialysis	YES	NO
38. Congenital heart disease	YES	NO	58. Rheumatic fever	YES	NO
39. Convulsions	YES	NO	59. Rheumatic heart disease	YES	NO
40. Colorectal Cancer	YES	NO	60. Sleep apnea	YES	NO
41. Diabetes	YES	NO	61. Stroke	YES	NO
42. Emphysema	YES	NO	62. Stomach disease	YES	NO
43. Epilepsy or Seizures	YES	NO	63. Tuberculosis	YES	NO
44. Excessive bleeding	YES	NO	64. Venereal Disease	YES	NO
45. Fainting spells/Dizziness	YES	NO	If yes, describe: _____		

DENTAL HISTORY

Date of your last visit to a dentist: _____
Reason for your last visit (or series of visits): _____
Name of previous dentist: _____
What is your chief complaint for today's visit: _____
Are you experiencing any of the following symptoms: (please place a check mark next to all that apply)

____ Bleeding gums
____ Toothache
____ TMJ pain/clicking
____ Grinding / Clenching
____ Food catching/impacting between teeth
____ Shifted or loose teeth
____ Sensitivity to hot / cold / pressure / sweets
____ Frequent headaches