REGISTRATION FORM / MEDICAL-DENTAL HISTORY

PATIENT REGISTRATION FOR: ____

Residence Address	
Telephone	Referred By
Other Family Members in the Practice	Preferred Time for Appointments
SSN - -	DOB / /
Marital Status S M D W	Spouse's Name
If Minor, Name of Guardian	Address & Telephone
Person Responsible for Fee (if other than patient)	Relationship to Patient
Billing Address (if different from above)	**Email** :
Occupation	Will you receive calls at work? ☐ Yes ☐ No
Employer's Name & Telephone	
EMERGENCY NOTIFICATION Name & Telephone	

INSURANCE INFORMATION

	Primary Carrier	Secondary Carrier
Name of Insurance Company		
Address		
Telephone		
Subscriber's Name/ Relationship to Patient	/	/
Name of Group Policyholder or Union		
Group Policy # / Individual Policy #	/	/
Effective Date / Time Limit for Claims	/	/
Pre Estimate Required	☐ Yes ☐ No	☐ Yes ☐ No
Method of Payment	☐ UCR ☐ Schedule of Payments ☐ Other	☐ UCR ☐ Schedule of Payments ☐ Other
Coinsurance	Company ________ % Patient ________%	Company ________ % Patient________ %
Deductible	☐ Yes ☐ No ☐ Individual ☐ Family ☐ Annual $ ________ ☐ Lifetime $ _________	☐ Yes ☐ No ☐ Individual ☐ Family ☐ Annual $ ________ ☐ Lifetime $_________
Plan Covers Orthodontics	☐ Yes ☐ No	☐ Yes ☐ No
Other		
If credit card payment is accepted:	Name of Card:	
	Card #	Expiration Date

Medical History

INSTRUCTIONS

"I understand that honest answers to the questions stated below are important to the provision of my dental care, and that I will answer them to the best of my ability. I have been informed that if I am uncertain about the question or how the question related to my health status, I must discuss the problem with the doctor or a member of the office staff. I understand that all questions must be answered. I have been assured that the information I provide will not be released without my express permission."

Patient's Initials___________ Dentist's Initials____________

To receive treatment in this office you must answer all questions on this history form.

The questions asked relate directly to the safe and effective treatment you are to receive in the office – to the best of your ability honest answers must be given.

If you are unsure of the question, unsure of your answer, or whether the question relates to your medical condition, you are to discuss the matter with the doctor.

Some of the questions may not relate to you or your medical condition; in that event you are to write "N/A" (not applicable) in the space provided.

All questions must be answered and written in ink.

To properly evaluate your current health status it may be necessary for the dentist to contact your physician. Included on this form is "Permission to Release Information." You are asked to sign it in the presence of a member of the office staff.

ALL INFORMATION YOU SUPPLY TO THE OFFICE ON THIS FORM, AND THE SUBSEQUENT INTERVIEW BY THE DENTIST AND INFORMATION 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. Name, address & phone # of your physician ____
2. Date of last visit to your doctor __________ Purpose of visit ____
3. Do you suffer from any disability? ________ If yes, describe ____

   ____
4. Have you ever, or do you now take illegal drugs? ________ If yes, what drugs, and when taken? ____________________________

   ____

   Note: There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal.
5. Do you have AIDS, or are you HIV-positive? _________ If yes, describe and provide current status. __________________________

   ____
6. Do you now have, or have you ever had a venereal disease? _______ If yes, describe.____________________________________
7. Have you ever had, or do you now have hepatitis? ______ If yes, describe.____
8. For females: Are you pregnant? _________ If yes, when are you due? ____
9. For females: Are you taking birth control pills? __________

   Note: There are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills.
10. List all medications you are now taking or have taken previously on a regular basis, describe the strength and purpose for each.

    ____

    ____

    Note: There are many drugs and medications when mixed with other drugs and/or medications may cause complications, some of which may result in dangerous health problems. Information about your current use of drugs and medications is essential.
11. Have you ever had an allergic reaction to medication? ________ If yes, describe. ____
12. Have you lost weight recently? __________ If yes, describe. ____

Have You Ever Had Or Been Treated For:

13. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease? ______________________________
14. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats? _________________________________
15. Stomach or intestinal disease? ____

Medical History [continued]

16. Abnormal blood pressure, excessive bleeding, or anemia? ______________________________

17. Breathing problems, asthma, tuberculosis, or hay fever? ______________________________

18. Cancer, X-ray treatments, chemotherapy, or IV bisphosphonate (i.e. Zometa or Aredia) treatment? ______________________________

____

19. Diabetes? ______________________________

20. Kidney problems or renal dialysis? ______________________________

21. A stroke, convulsions, or fainting spells? ______________________________

22. Tumors or growths? ______________________________

23. Arthritis or rheumatism? ______________________________

24. Have you ever had a major operation? ____________ If yes, describe.______________________________

____

25. Have you ever had a serious injury to your head or neck? ____________ If yes, describe. ______________________________

____

26. Are you on a special diet? ____________ If yes, for what reason and describe.______________________________

27. Do you smoke? ____________ If yes, describe type and quantity.______________________________

28. Have you consulted or been treated by a psychiatrist, psychologist, or counselor? ____________ If yes, when and describe.

____

29. Do you consume any alcoholic beverages? If yes, how much and how often? ______________________________

30. Are there any other problems about your health of which you are aware? ______________________________

____

31. For children under 10 years old: Was the child born by Cesarean Section? ______________________________

32. Females: Are you currently taking any bisphosphonate medication? ______________________________

33. Have you had any prosthetic joint replacement? ______________________________

34. Are you allergic to latex? ______________________________

35. Do you ever notice that your feet and/or ankles are swollen? ______________________________

36. Are you aware of any swollen glands in your neck? ______________________________

Dental History

1. Name of previous dentist ______________________________ Date of your last visit ____________

2. Reason for your last visit (or series of visits) ______________________________

3. Do you have any of your X-rays or dental records? ______________________________

4. Chief dental complaint if any? ______________________________

In respect to any previous dental treatment have you:

5. Ever fainted? ______________________________

6. Had an allergic reaction? ______________________________

7. Had abnormal bleeding? ______________________________

8. Any other complications during or following dental treatment? ____________ If yes, describe. ____________

____

9. Do your gums bleed on brushing or eating? ______________________________

10. Does food catch between your teeth? ______________________________

11. Have your teeth shifted, are there spaces between your teeth now where there were none, are your teeth flaring, or are some of your teeth becoming loose? ______________________________

Dental History [continued]

12. Are any of your teeth sensitive to heat, cold, or pressure? ______________________________

13. Do you grind your teeth or clench your jaws? ______________________________

14. Do you have pain or clicking in the jaw joint in front of your ear? ______________________________

____

15. Have your jaw muscles ever been sore? ________________ If yes, describe.______________________________

____

16. Are there any sores or growths in your mouth? ______________________________

____

17. Do any of your teeth ache? ______________________________

18. Do you have any other dental complaint? ______________________________

____

To the best of my knowledge, the foregoing questions have been accurately answered.

NOTE: A change in your health status should be reported to the office immediately.

"I understand that should there be a change in my health during my dental treatment, I am to inform the dentist at the earliest possible time."

Patient's Initials____________ Dentist's Initials__________

Permission To Release Health Information

I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payers, and/or health practitioners.

Person completing the form: ______________________________ Signature______________________________

Witness ______________________________ Print Name______________________________

If other than patient, indicate relationship______________________________Date____________________

Dentist's History Review & Significant Findings: ______________________________

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Signature: Dr. ______________________________ Date: ______________________________

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