PATIENT INFORMATION

Patient's name _____ Preferred name _____ Birth date_____

DENTAL HISTORY

- ❑ Sensitivity to COLD HOT SWEETS
- ❑ Sensitivity to biting
- ❑ Broken Teeth
- ❑ TMJ(Jaw lock, clicks, pops, hurts)
- ❑ BAD EXPERIENCES(explain)

  _____
- ❑ Sores or Growths
- ❑ Pain in muscles
- ❑ Food collection between teeth
- ❑ Headaches
- ❑ Clenching or grinding
- ❑ Loose teeth

Last dental exam _____

Last dental xrays_____

Previous dentist's name /contact info_____

MEDICAL HEALTH HISTORY

Have you EVER HAD or Currently Have the following

(Please check any that apply)—place date if in past

- ❑ **Cancer or tumor**
- ❑ **Heart attack**
- ❑ **Stroke or TIA**
- ❑ **Previous endocarditis**
- ❑ **Bypass or stent**
- ❑ **Shortness of breath**
- ❑ **Heart defect**
- ❑ **Artificial joint/replacement**
- ❑ **Artificial heart valve**
- ❑ **High or low blood pressure**
- ❑ **Pacemaker**
- ❑ **Excessive/abnormal bleeding**
- ❑ **Kidney disease/disorder**
- ❑ **Dry mouth**
- ❑ **Gerd(heart burn)/ stomach ulceer**
- ❑ **Colitis**
- ❑ **Hepatitis C or other liver disease**
- ❑ **Blood transfusion**
- ❑ **Diabetes**
- ❑ **Autoimmune disease**
- ❑ **HIV/AIDS**
- ❑ **Rheumatism**
- ❑ **Arthritis**
- ❑ **Back problems**
- ❑ **Epilepsy, seizures, or fainting spells**
- ❑ **Nervousness/anxiety**
- ❑ *ARE YOU REALLY READING THESE?*
- ❑ **Herpes or cold sores**
- ❑ **Shingles**
- ❑ **AIDS or HIV positive**
- ❑ **Alcoholism**
- ❑ **Substance abuse**
- ❑ **Venereal disease**
- ❑ **Migraine headaches or frequent headaches**
- ❑ **Anemia or blood disorders**
- ❑ **Hayfever or sinus trouble**
- ❑ **Allergies or hives**
- ❑ **Tuberculosis or other lung problems**
- ❑ **Cough(persistent)**
- ❑ **Respiratory disease**
- ❑ **Asthma**
- ❑ **Thyroid disorder (hyper or hypo)**
- ❑ **Tobacco habit**

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocaine")
- ❑ Codeine or other narcotics
- ❑ Aspirin
- ❑ NSAIDS
- ❑ Other:_____

  _____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Thyroid medication
- ❑ Chemotherapy
- ❑ Anticoagulants **(blood thinners)**
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin
- ❑ Diabetic medication other than insulin
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Herbal or other supplements
- ❑ Other:_____

  _____

  __

Women:

- ❑ May be pregnant

  Expected delivery date: _____

Name of your physician:_____Phone/contact info_____

Do you have any disease, condition, or problem not listed above?_____

_____

Signature of patient (or parent) _____Date _____

REGISTRATION

Name_____
Last First Initial

Please circle, if applicable: Jr. Sr. III Dr. Rev. Sis.

Date of Birth:_____ ♢ Female ♢ Male
Address: Street_____ P.O. Box_____
City_____ State_____ Zip_____
Place of Employment_____
Social Security #_____
Phone Numbers (please include area codes):
Home_____ Work_____
Cell_____ Fax_____

Whom may we thank for this referral? _____

Emergency Information: Who may we contact in case of an emergency?

Name_____ Phone #_____

If you do not have dental insurance, you may skip this next section.

Name of insurance company:_____
Phone #:_____ Group #_____
Name of policy holder:_____
Relationship of policy holder to you:_____
Policy holder's social security #_____ D.O.B._____
Employer:_____

Release:
I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize release of any information concerning my health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
I authorize release of any information concerning my health care, advice, and treatment to another dentist, specialist or health care provider
I hereby authorize payment of insurance benefits directly to the dentist. If insurance policy pays the patient rather than the dentist, patient is responsible for making payment to the dentist.
I attest to the accuracy of information on this page.

Signature_____ Date_____