HEALTH HISTORY & REGISTRATION

Title: Mr., Mrs., Ms. _____

Patient's Name _____ Home Phone Number ( ) - _____

Cell Number ( ) - _____ Email _____

Home Address _____ Work Number ( ) - _____

City _____ State _____ Zip _____

Social Security # _____ Sex: M F Age _____ Birth date ___/___/___

Occupation _____

Employer (Parents if minor) _____

Name of Spouse (Parent if minor) _____

Spouse's Work Phone Number (Parent if minor) ( ) - _____

Referred to us by _____ Reason for Visit _____

Who is responsible for this account? _____ Phone: _____

EMERGENCY INFORMATION:

Contact Name _____ Daytime Phone Number _____

Address _____

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

MEDICAL INFORMATION

	Yes	No
Are you in good health?	❑	❑
Has there been any change in your general health within the past year?	❑	❑
Are you now under the care of a physician?	❑	❑

If yes, what is/are the condition(s) being treated? _____

_____

Date of last physical examination: _____

Physician: _____ Town _____

Have you had any serious illness, operation, or been hospitalized in the past 5 years? ❑ ❑

If yes, what was the illness or problem? _____

_____

_____

Are you allergic to or have had a reaction to?	**Yes**	**No**
Local anesthetics	❑	❑
Aspirin, Advil, NSAIDS	❑	❑
Penicillin	❑	❑
Other antibiotics	❑	❑
Barbiturates, sedatives, or sleeping pills	❑	❑
Sulfa drugs	❑	❑
Codeine or other narcotics	❑	❑
Latex	❑	❑
Iodine	❑	❑
Hay fever/seasonal	❑	❑
Animals	❑	❑
Food (specify) _____	❑	❑
Other (specify) _____	❑	❑
Metals (specify) _____	❑	❑

To yes responses, specify type of reaction. _____

_____

_____

Are you taking:

Recreational drugs?	❑ Yes	❑ No
Tobacco in any form?	❑ Yes	❑ No
Over-the-counter medicines, aspirins, natural remedies.	❑ Yes	❑ No
Alcohol	❑ Yes	❑ No

Please list any and all medications you are taking:

_____

_____

_____

Are you taking or have you ever taken any medication for Osteoporosis? ❑ Yes ❑ No

If yes, which drug and for how long? _____

_____

Have you taken a drug called Cortisone, Steroid, or ACTH within the past two years?	❑	❑
Have you ever taken any blood thinners in the past week?	❑	❑
Do you bruise easily or bleed excessively?	❑	❑

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❑ ❑

If yes, why? _____

If yes, what antibiotic and dose? _____

_____

Please (X) a response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No
Abnormal bleeding	❑	❑
AIDS or HIV infection	❑	❑
Anemia	❑	❑
Arthritis	❑	❑
Any radiation to head or neck	❑	❑
Asthma / C.O.P.D.	❑	❑
Blood Transfusion. If yes, date:_____	❑	❑
Cancer/Chemotherapy/Radiation Treatment	❑	❑
Cardiovascular disease. If yes specify below:	❑	❑

_____ Angina
_____ Arteriosclerosis
_____ Artificial heart valves
_____ Atrial Fibrillation
_____ Arrythmia
_____ Automatic Implantable Cardiodefibrillator (ACID, ICD)
_____ Congenital heart defects
_____ Congestive heart failure
_____ Coronary artery disease
_____ Damaged heart valves
_____ Heart attack
_____ Heart murmur
_____ High blood pressure
_____ Low blood pressure
_____ Mitral valve prolapse
_____ Pacemaker
_____ Rheumatic heart disease/Rheumatic fever
_____ Stents

Chest pain upon exertion	❑	❑
Chronic pain	❑	❑
Disease, drug, or radiation-induced immunosupression	❑	❑
Diabetes. If yes, specify below:	❑	❑
_____ Type I (Insulin dependent) _____Type II		
Dry Mouth	❑	❑
Eating disorder. If yes specify:_____	❑	❑
Fainting spells	❑	❑
History of seizures	❑	❑
Reflux/GERD	❑	❑
Glaucoma	❑	❑
Do you have loose teeth, or full or partial dentures?	❑	❑
Do you have a chronic cough?	❑	❑
Do you cough up any material?	❑	❑

	Yes	No
Hemophilia	❑	❑
Hepatitis, jaundice or liver disease	❑	❑
HPV	❑	❑
If yes, what year was diagnosis:_____		
Recurrent Infections	❑	❑
If yes, indicate type of infection:_____		
Kidney problems	❑	❑
Mental health disorders. If yes, specify:_____	❑	❑
_____		
Night sweats	❑	❑
Neurological disorders. If yes, specify:_____	❑	❑
_____		
Osteoporosis	❑	❑
Persistent swollen glands in neck	❑	❑
Respiratory problems. If yes, specify below:	❑	❑
____Emphysema _____Bronchitis, etc.		
Severe headaches/migraines	❑	❑
Sexually transmitted disease	❑	❑
Sinus problems	❑	❑
Sleep disorder	❑	❑
Sores or ulcers in the mouth	❑	❑
Stroke	❑	❑
Systematic lupus erthematosus	❑	❑
Tuberculosis	❑	❑
Thyroid problems	❑	❑
Stomach Ulcers	❑	❑
Excessive urination	❑	❑

	Yes	No
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	❑	❑

If yes, when was this operation done?_____

If you answered yes to the above question, have you been placed on antibiotics before dental treatment? If so, which antibiotic?

WOMEN ONLY

Are you or could you be pregnant?	❑	❑
Nursing?	❑	❑
Taking birth control pills or hormonal replacement?	❑	❑

ALL PATIENTS

Do you have or have you had any other diseases or medical problems NOT listed on this form? ❑ Yes ❑ No

If so, please explain: _____

CONSENT:

To my knowledge I have answered every question completely and accurately. I will inform the dentist of any change in my health and medications. I also understand the use of anesthetic agents embodies a certain risk. I acknowledge that all appointments require a 24 hour minimum cancellation notice during normal business hours to avoid a fee. I understand that responsibility for payment for dental services provided in this office for myself or my dependent is mine, due and payable at the time services are rendered unless financial arrangements have been made. It is my responsibility to fully understand my insurance and health saving account plans. I am responsible for all charges. I also understand that if I do not have insurance coverage, I am responsible for payment in full. To avoid being sent to collection, all accounts over 60 days must be settled. I agree to pay 1% per month interest (or a $25 late fee, whichever is greater) on any past due balances, and in the case the account is referred to collection (60 days past due). I agree to pay all costs of collection including, but not limited to a 29% collection agency fee, reasonable attorney fees and court costs.

1. Patient's signature: _____ Dentist signature: _____ Date _____
(Legal guardian if patient is a minor)

2. Patient's signature: _____ Dentist signature: _____ Date _____
(Legal guardian if patient is a minor)

3. Patient's signature: _____ Dentist signature: _____ Date _____
(Legal guardian if patient is a minor)