

PLEASE PRINT AND COMPLETE ALL INFORMATION BELOW

PATIENT _____
Last First Middle Initial Nickname

Date of Birth ____/____/____ Male Female Single Married Divorced Widowed Separated

Address _____ Home Phone _____

City State Zip Soc. Sec. E-Mail _____

Employer _____ Business Phone _____ Cell Phone _____

Address _____ Occupation _____

City State Zip

Spouse's Name _____ Soc. Sec. _____

Date of Birth ____/____/____ Employer _____

Address _____ Occupation _____

Business Phone _____

City State Zip

Referred By _____ General Dentist _____

In case of emergency, local friend or relative to be notified (not living at same address).

Name _____ Relationship To Patient _____

Address _____ Phone _____

PERSON RESPONSIBLE FOR BILL, IF NOT PATIENT

Name _____ Relationship To Patient _____

Address _____ Soc. Sec. _____

City State Zip Phone _____

Employer _____ Business Phone _____

Address _____

DENTAL INSURANCE INFORMATION

Primary Insurance Co. _____ Patient's Relationship to Subscriber
 Self Spouse Dependent

Subscriber's Name _____ Soc. Sec. _____

Ins. Co. Billing Address _____ Date of Birth ____/____/____

Group # _____ Identification# _____ Ins. Co. Phone _____

Secondary Insurance Co. _____ Patient's Relationship to Subscriber
 Self Spouse Dependent

Subscriber's Name _____ Soc. Sec. _____

Ins. Co. Billing Address _____ Date of Birth ____/____/____

Group # _____ Identification # _____ Ins. Co. Phone _____

The above information is complete and accurate to the best of my knowledge.

Patient's or Guarantor's Signature Date

Thank you for the accurate information.

REGISTRATION

Name _____

Date of birth _____ Weight _____ Height _____ [] male [] female

Please answer all questions by circling either YES or NO and complete the blank spaces as indicated.

MEDICAL HISTORY

- [Yes] [No] 1. Are you presently under the care of a physician?
a. Name of physician: _____
b. Condition (s) being treated: _____
- [Yes] [No] 2. Have you had a physical examination within the last two years?
a. Date of examination: _____
b. Reason for the examination : _____
- [Yes] [No] 3. Have you ever been hospitalized?
a. Date of hospitalization: _____
b. Condition (s) treated: _____
- [Yes] [No] 4. Do you have any allergies?
a. Drug (ie, Penicillin, Aspirin, Codeine): _____
Materials (ie, Latex, Talcum): _____
- [Yes] [No] 5. Are you presently taking any medication (including Contraceptives)?
a. Medications: _____
b. Dosages: _____
- [Yes] [No] 6. Have you ever been treated for a tumor, cancer or malignancy?
a. Date of Occurrence: _____
b. Treatment (ie, surgical removal, chemotherapy, radiation therapy): _____
- [Yes] [No] 7. Do you use tobacco products? _____ Smokeless _____ Smoke _____ Number of packs per day
_____ Number of years of use
8. How much alcohol do you consume on the average, per week? _____

CARDIOVASCULAR

- [Yes] [No] 9. Have you ever had rheumatic fever or rheumatic heart disease?
- [Yes] [No] 10. Do you have congenital heart defect?
- [Yes] [No] 11. Do you have a prosthetic heart valve?
- [Yes] [No] 12. Do you have a pacemaker?
- [Yes] [No] 13. Has a doctor ever told you that you had a heart murmur or an abnormal sound associated with your heart?
- [Yes] [No] 14. Are you being treated for or do you have high blood pressure?
- [Yes] [No] 15. Have you ever had a heart attack?
a. Date: _____
b. Treatment following the attack: _____
- [Yes] [No] 16. Have you ever had a stroke?
- [Yes] [No] 17. Do you ever have chest pains (Angina Pectoris)?
a. Frequency: _____
b. Duration: _____

RESPIRATORY

- [Yes] [No] 18. Do you ever have Edema (swelling of the ankles)?
- [Yes] [No] 19. Have you ever had or lived with anyone who has had tuberculosis?
- [Yes] [No] 20. Do you have Emphysema?
- [Yes] [No] 21. Do you suffer from frequent cold, sore throats, or sinusitis?
- [Yes] [No] 22. Do you have Asthma?
a. Frequency: _____
b. Cause of Asthmatic attacks: _____
- [Yes] [No] 23. Do you have shortness of breath?
- [Yes] [No] 24. Do you ever have labored breathing (Dyspnea) on exertion?
- [Yes] [No] 25. Do you require two or more pillows to sleep comfortably?

HEMATOPOIETIC

- [Yes] [No] 26. Have you ever tested positive for H.I.V. or been advised you have AIDS?
- [Yes] [No] 27. Have you ever been anemic?
- [Yes] [No] 28. Do you bleed or bruise more easily than other people?
- [Yes] [No] 29. Have you ever or are you presently taking anticoagulants (blood thinner)?
- [Yes] [No] 30. Have you ever required a blood transfusion?
- [Yes] [No] 31. Have you ever been denied permission to give blood (blood donor)?
- [Yes] [No] 32. Do injuries or cuts take longer to heal now than they did in the past?

OVER

ENDOCRINE

- [Yes] [No] 33. Do you have Sugar Diabetes (Diabetes Mellitus)?
 a. At what age were you first aware of this condition? _____
 b. Other family members with diabetes.

- [Yes] [No] 34. Do you urinate (pass water) more than two times at night?
- [Yes] [No] 35. Are you thirsty most of the time?
- [Yes] [No] 36. Does your mouth feel dry or do you have a burning sensation of your lips or tongue?
- [Yes] [No] 37. Are you now on a prescribed diet?
- [Yes] [No] 38. Have you ever had a Thyroid or Parathyroid disorder or problem?
- [Yes] [No] 39. Have you received / taken any cortisone medication in the past year?

GENITOURINARY

- [Yes] [No] 40. Do you frequently have kidney infection?
- [Yes] [No] 41. Have you ever received dialysis treatment for kidney failure?
- [Yes] [No] 42. Have you ever had Syphilis, "Bad Blood", Gonorrhoea, or a venereal disease?

FEMALES

- [Yes] [No] 43. Are you pregnant? Or nursing?
- [Yes] [No] 44. Are your menstrual cycles regular?
- [Yes] [No] 45. Have you reached Menopause?
- [Yes] [No] 46. Do you take an Estrogen or other Hormonal supplements?

GASTROINTESTINAL

- [Yes] [No] 47. Have you ever had a stomach, duodenal or peptic ulcer?
- [Yes] [No] 48. Are your stools ever black in color?
- [Yes] [No] 49. Have you ever had Hepatitis or Yellow Jaundice?
- [Yes] [No] 50. Are you recovering from alcohol or drug addiction?
- [Yes] [No] 51. Do you use illicit drugs? (ie, marijuana, cocaine,)

MUSCULOSKELETAL

- [Yes] [No] 52. Do you suffer with arthritis (rheumatism)?
 a. Type _____
 b. Affected joints _____
 c. Treatment _____
- [Yes] [No] 53. Do you have an artificial joint implant?
- [Yes] [No] 54. Have you ever had a muscle or joint disorder?
- [Yes] [No] 55. Have you ever been diagnosed as having Glaucoma?
- [Yes] [No] 56. Have you ever taken any bone density Medications (Prolia, Fosamax, Aredia, Zometa, Actonel)? Do you have osteoporosis or osteopenia?

NEUROLOGICAL

- [Yes] [No] 57. Have you ever fainted?
- [Yes] [No] 58. Are you troubled by nervousness or tension?
- [Yes] [No] 59. Have you ever had fits, seizures, convulsions or epilepsy?
- [Yes] [No] 60. Have you ever been treated or taken medications for an emotional problem?
- [Yes] [No] 61. Have you ever been treated or taken medication for nerves?

DENTAL HISTORY

- [Yes] [No] 1. Are you under the routine care of a general dentist?
 a. Name of dentist _____ City, State _____
 b. Length of time under care _____ Interval of visits _____
- [Yes] [No] 2. Do you require antibiotic pre-medication before your dental appointments?
- [Yes] [No] 3. Do you presently have dental pain?
 a. How long _____
 b. Location _____
- [Yes] [No] 4. Is heat, cold, sweets or chewing uncomfortable to your teeth?
- [Yes] [No] 5. Do your gums bleed upon brushing?
- [Yes] [No] 6. Are you conscious of a bad taste in your mouth or bad breath?
- [Yes] [No] 7. Are you conscious of any loose teeth?
- [Yes] [No] 8. Have you had previous periodontal treatment?
 a. When _____
 b. Year completed _____
- [Yes] [No] 9. Have you had orthodontic treatment (braces)?
 a. By whom _____
 b. Duration _____
- [Yes] [No] 10. Do you clench or grind your teeth during the day or night?
- [Yes] [No] 11. Do you wear a night guard or bite appliance?
- [Yes] [No] 12. Do you awaken with aches in the face, temple or jaw joints?
- [Yes] [No] 13. Does one tooth appear to touch before the others?
- [Yes] [No] 14. Do you have any difficulty (pain, clicking, popping, etc.) when you open or close your mouth?
- [Yes] [No] 15. Have you noticed spaces developing between your teeth?
- [Yes] [No] 16. Have you noticed your bite changing?
- [Yes] [No] 17. Have you ever been informed that you were allergic to or could not receive local anesthetic (Novocain)?
- [Yes] [No] 18. Have you ever bled for more than two days following an extraction or dental procedure?
- [Yes] [No] 19. Have you ever had any serious trouble associated with any previous dental experience?

The above information is complete and accurate to the best of my knowledge.

Signature _____

Date _____