ADULT'S REGISTRATION AND DENTAL HISTORY

PATIENT NAME _____ DATE _____

ADDRESS _____ PATIENT'S BIRTHDATE _____

CITY, STATE, ZIP _____ SPOUSE'S BIRTHDATE _____

PHONE: ❑ HOME _____ ❑ BUSINESS _____ IF UNDER 21 YEARS OF AGE:

❑ CELL _____ FATHER'S BIRTHDATE _____

*Please put a number 1-3 in the order in which it is best to reach you. MOTHERS BIRTHDATE _____

EMAIL _____

INSURANCE FOR THIS PATIENT IS PROVIDED BY MYSELF SPOUSE BOTH PARENT

INSURANCE INFORMATION

PRIMARY:	SECONDARY:
SUBSCRIBER NAME _____	SUBSCRIBER NAME _____
PLACE OF EMPLOYMENT _____	PLACE OF EMPLOYMENT _____
DENTAL INSURANCE CO. _____	DENTAL INSURANCE CO. _____
INSURANCE CO. PHONE # _____	INSURANCE CO. PHONE # _____
GROUP/POLICY # _____	GROUP/POLICY # _____
CONTRACT ID # _____ SS# _____	CONTRACT ID # _____ SS# _____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED _____ SAME HOUSEHOLD _____

PHONE # _____ RELATION TO PATIENT _____

HOW DID YOU HEAR ABOUT OUR OFFICE _____

WHY DID YOU CHANGE DENTISTS _____

WHO WILL PAY THIS ACCOUNT _____

ARE YOU HAVING DISCOMFORT AT THIS TIME _____ WHERE _____

DATE OF LAST DENTAL VISIT _____ FOR WHAT SERVICE _____

HOW FREQUENT WERE VISITS BEFORE THEN _____

HOW OFTEN IS TOOTHBRUSHING DONE _____ WHEN _____

DO YOU USE DENTAL FLOSS _____ HOW OFTEN _____

WOULD YOU LIKE YOUR TEETH TO BE WHITER _____

WOULD YOU LIKE YOUR TEETH TO BE STRAIGHTER _____

DO YOUR GUMS BLEED WHEN YOU BRUSH YOUR TEETH _____

DO YOU HAVE ANY FEAR OF HAVING DENTISTRY DONE _____ WHY _____

WHAT QUESTIONS OR CONCERNS DO YOU WANT THE DOCTOR TO ADDRESS _____

_____

_____

AUTHORIZATION TO PAY BENEFITS TO DENTIST:

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTIST OF THE INSURANCE BENEFIT OTHERWISE PAYABLE TO ME FOR HIS SERVICE.

PATIENT SIGNATURE _____ DATE _____

Other Side. Please

HEALTH HISTORY

PHYSICIAN'S NAME _____ ADDRESS _____ PHONE_____

DATE OF LAST PHYSICAL EXAM _____

YES NO

❑ ❑ ARE YOU UNDER CARE OF PHYSICIAN NOW _____ FOR WHAT CONDITIONS _____

❑ ❑ ARE YOU TAKING ANY MEDICATION OR DRUGS _____
please list, including vitamins and birth control

❑ ❑ IS THERE ANY EXCESSIVE BLEEDING WHEN CUT _____

❑ ❑ HAVE YOU EVER BEEN HOSPITALIZED_____ IF SO WHY _____

❑ ❑ HAVE YOU EVER HAD SURGERY _____

❑ ❑ IS THERE ANY ALLERGY TO PENICILLIN _____

❑ ❑ IS THERE ANY ALLERGY TO LOCAL ANESTHETIC_____

❑ ❑ ARE THERE ANY OTHER ALLERGIES: DRUGS. FOOD, POLLEN. ETC _____

❑ ❑ ARE THERE ANY PHYSICAL CONSIDERATION WE SHOULD KNOW ABOUT (BACK PROBLEMS, ETC.) _____

_____

❑ ❑ DO YOU HAVE ANY ALLERGY TO LATEX _____

❑ ❑ ARE YOU A SMOKER OR DO YOU CHEW TOBACCO _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

_____ Abnormal Heart Condition

If so, please list your Cardiologist's Name & Phone Number

_____

_____ Anemia
_____ Arthritis
_____ Asthma
_____ Circulatory Problems
_____ Convulsions
_____ Diabetes
_____ Epilepsy
_____ Fainting
_____ Hepatitis
_____ Herpes
_____ High Blood Pressure
_____ Low Blood Pressure

ARE YOU PREGNANT_____

_____ Malignancies (Cancer)
_____ Mononucleosis
_____ Nervous Problems
_____ Organ Transplant
_____ Psychiatric Care
_____ Radiation Treatment
_____ Rheumatic Fever
_____ Sinus Problems
_____ Stroke
_____ Thyroid
_____ T.M.J.
_____ Tuberculosis
_____ Ulcer
_____ Venereal Disease
_____ A.I.D.S
_____ H.I.V. Positive

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT. IMPENDING OPERATIONS. OR ANY OTHER MEDICAL OR DENTAL INFORMATION THAT MAY POSSIBLY AFFECT YOUR DENTAL TREATMENT.

_____

_____

PATIENT SIGNATURE _____ DATE_____