# ADULT REGISTRATION AND DENTAL HISTORY

PATIENT NAME ________________________________________

ADDRESS ________________________________________

CITY, STATE, ZIP________________________________________

BIRTHDATE________________________________________

PHONE: HOME ________________ BUSINESS________________

CELL________________________________________

OCCUPATION________________________________________

EMAIL________________________________________

DATE________________________________________

SPOUSE'S NAME ________________________

SPOUSE'S BIRTHDATE ____________________

SPOUSE'S CELL ________________________

IF UNDER 21 YEARS OF AGE:

FATHER'S BIRTHDATE ____________________

MOTHERS BIRTHDATE ____________________

INSURANCE FOR THIS PATIENT IS PROVIDED BY MYSELF SPOUSE BOTH PARENT

## INSURANCE INFORMATION

PRIMARY:

SUBSCRIBER NAME ____________________________

PLACE OF EMPLOYMENT ________________________

DENTAL INSURANCE CO. ________________________

INSURANCE CO. PHONE # ______________________

GROUP/POLICY # ______________________________

CONTRACT ID # ________________ SS# ______________

SECONDARY:

SUBSCRIBER NAME ____________________________

PLACE OF EMPLOYMENT ________________________

DENTAL INSURANCE CO. ________________________

INSURANCE CO. PHONE # ______________________

GROUP/POLICY # ______________________________

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*

Patient Name | Date of Birth | Height | Weight | Date

Physician's Name ______________________________ Phone Number ______________________________

1. Are you in good health? ........ Y N
2. Has there been any change in your general health in the past year? ........ Y N
3. Date of last physical exam: ______________________
4. Are you now under a physician's care for a particular problem? ........ Y N
5. Have you **ever** had any serious illnesses, operations, or hospitalizations? ........ Y N
   If so, describe: ______________________________
   ______________________________
6. **DO YOU HAVE OR HAVE YOU EVER HAD**:
   A. Rheumatic Fever or Rheumatic Heart Disease? ........ Y N
   B. Congenital Heart Disease? ........ Y N
   C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? ........ Y N
   D. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Sever Coughing)? ........ Y N
   E. Seizures, Convulsions, Epilepsy, Fainting, or Dizziness? ........ Y N
   F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ........ Y N
   G. Liver Disease (Jaundice, Hepatitis)? ........ Y N
   H. Kidney Disease? ........ Y N
   I. Diabetes? ........ Y N
   J. Thyroid Disease (Goiter)? ........ Y N
   K. Arthritis? ........ Y N
   L. Stomach Ulcers or Colitis? ........ Y N
   M. Glaucoma? ........ Y N
   N. Osteoporosis? ........ Y N
   O. Implants places anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ........ Y N
   P. Radiation (X-ray) treatment for Cancer? ........ Y N
   Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ........ Y N
   R. Sinus or Nasal problems? ........ Y N
   S. Any disease, drug, or transplant operation that has suppressed your immune system? ........ Y N
   T. Sleep Apnea? ........ Y N
7. **ARE YOU USING ANY OF THE FOLLOWING**:
   A. Antibiotics? ........ Y N
   B. Anticoagulants (Blood Thinners)? ........ Y N
   C. Aspirin or drugs such as Motrin, Aleve, or Ibuprofen? ... Y N
   D. High Blood Pressure medications? ........ Y N
   E. Steroids (Cortisone, Prednisone, etc.)? ........ Y N
   F. Tranquilizers? ........ Y N
   G. Insulin or Oral Anti-Diabetic drugs? ........ Y N
   H. Digitalis, Inderal, Nitroglycerin or other heart drug? ..... Y N
   I. Are you taking or ***have you ever taken*** Bisphosphonates for osteoporosis, multiple myeloma, or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia)? ...... Y N
   J. Have you ever been advised not to take a medication? ........ Y N
   K. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins, or minerals: ______________________________
   ______________________________
8. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO**:
   A. Local Anesthesia (Novacain, etc.)? ........ Y N
   B. Penicillin or other antibiotics? ........ Y N
   C. Sedatives, Barbiturates? ........ Y N
   D. Aspirin or Ibuprofen? ........ Y N
   E. Codeine or other pain killers? ........ Y N
   F. Latex or Rubber products? ........ Y N
   G. Metal of any kind? ........ Y N
   H. Chemicals or jewelry (rash or sensitivity)? ........ Y N
   I. Food products? ........ Y N
   J. Other allergies or reactions? ........ Y N
   Please list: ______________________________
   ______________________________
9. Do you smoke or chew Tobacco? ........ Y N
   How much per day? ______________________________
10. Is there any history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ........ Y N
11. Have you had any serious problems associated with any previous dental treatment? ........ Y N
12. Have you or an immediate family member had any problem associated with intravenous anesthesia? ........ Y N
13. Do you have any other disease, condition, or problem not listed above that you think the doctor should know about? ........ Y N
14. Do you wish to talk to the doctor privately about anything? ........ Y N
15. Have you ever had a bone density scan? ........ Y N
16. **FOR WOMEN ONLY**:
   A. Are you Pregnant, or ***is there any chance*** you might be Pregnant? ........ Y N
   B. Are you nursing? ........ Y N
   C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

**I understand the importance of a truthful and complete Health History to assist my dentist in providing the best care possible. I have had the opportunity to discuss my Health History with my dentist.**

______________ ______________________________ ______________

Date | Signature of Person Completing Health History | Doctor's Initials