Peregrine Family Dentistry, PC

HEALTH HISTORY AND REGISTRATION

PATIENT

Patient Name: Last _____First_____Middle Initial_____Nickname_____
Address: Street_____City_____State_____Zip Code_____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Employer: _____ Occupation: _____ Email: _____
Sex: ____Birth Date: _____ Marital Status: _____ Whom may we thank for referring you to our office? _____
Prefer reminders by: ☐ Phone ☐ Email ☐ Text

SPOUSE/PARENT/GUARDIAN INFORMATION

Name: Last _____First_____Middle Initial_____Marital Status:_____
Address: Street_____City_____State_____Zip Code_____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Employer: _____ Occupation: _____ Email: _____
Relationship to Patient: _____

DENTAL INSURANCE (PRIMARY CARRIER)

Insured's Name: _____
Insurance Co._____
Insurance Co. Address _____
Insured's Employer _____
Insured's SSN/ID #_____
Group _____
Insurance Co.Phone _____

SECONDARY (IF APPLICABLE)

Insured's Name: _____
Insurance Co._____
Insurance Co. Address _____
Insured's Employer _____
Insured's SSN/ID #_____
Group _____
Insurance Co. Phone _____

We need to know about your medical and dental history. This information is confidential. Thank you for taking the time to fill out this questionnaire.

MEDICAL HISTORY

Physician Name: _____ Office Phone: _____ Date of Last Medical Exam: _____
Are you currently under medical treatment?☐Yes☐No If yes, please describe _____
Have you had any serious illness or operations? ☐Yes ☐No If yes, please describe _____
Please list any medications you are taking (Prescription and Non-prescription):
_____
(Women) Are you pregnant? ☐Yes ☐No Due Date: _____ Nursing: ☐ Yes ☐No Taking birth control pills? ☐Yes ☐No

Please check if you have/had any of these conditions at any time. Check "Yes" or "No" to each item.

	Yes	No		Yes	No		Yes	No
Allergies/Hay fever	☐	☐	Hepatitis (Type ____)	☐	☐	STDs	☐	☐
Anemia	☐	☐	Herpes	☐	☐	Stroke	☐	☐
Anxiety	☐	☐	High blood pressure	☐	☐	Swelling of feet or ankles	☐	☐
Arthritis, Rheumatism	☐	☐	HIV/AIDS	☐	☐	Thyroid problems	☐	☐
Artificial Heart Valves	☐	☐	HPV infection	☐	☐	Tonsilitis	☐	☐
Artificial joints	☐	☐	Any immune deficiency	☐	☐	Trouble Swallowing	☐	☐
Asthma	☐	☐	Jaundice	☐	☐	Tuberculosis	☐	☐
Blood disease, clotting disorders	☐	☐	Kidney Disease	☐	☐	Tumor or growth on head/neck	☐	☐
Cancer	☐	☐	Low Blood Pressure	☐	☐	Ulcer	☐	☐
Chemical dependency	☐	☐	Mitral Valve Prolapse	☐	☐	Weight loss (unexplained)	☐	☐
Chemotherapy	☐	☐	Osteoporosis	☐	☐			
Circulatory problems	☐	☐	Pacemaker	☐	☐	**Allergies:**		
Cough, persistent or bloody	☐	☐	Radiation treatments	☐	☐	Antibiotics (ex. Penicillin)	☐	☐
Depression	☐	☐	Rheumatic fever	☐	☐	Sulfa Drugs	☐	☐
Diabetes (Type ____)	☐	☐	Scarlet fever	☐	☐	Aspirin	☐	☐
Emphysema	☐	☐	Shortness of breath	☐	☐	Sedatives	☐	☐
Epilepsy	☐	☐	Sinus trouble	☐	☐	Iodine	☐	☐
Fainting	☐	☐	Sickle cell anemia	☐	☐	Metals (nickel, copper, etc)	☐	☐
Gastric Reflux/Heartburn	☐	☐	Skin condition	☐	☐	Latex Rubber	☐	☐
Glaucoma	☐	☐	Sleep Apnea	☐	☐	Food _____		
Heart murmur	☐	☐	Slow healing wounds	☐	☐	Other _____		
Heart problems (other)	☐	☐	Steroid/Cortisone Therapy	☐	☐			

DENTAL HISTORY

Previous Dentist: _____ Date of Last Exam: _____

Reason for today's visit _____

How often do you brush? _____ How often do you floss?_____

Have you ever had an allergic reaction to Novocaine, local, or general anesthesia? ☐ Yes ☐ No
If yes, please explain: _____

Please check if you have/had:	Yes	No
Alcohol	☐	☐
Bad breath	☐	☐
Blisters/sores on lips or mouth	☐	☐
Burning sensation on tongue	☐	☐
Chewing on tongue/cheek/lip	☐	☐
Cigarette, pipe, cigar smoking	☐	☐
E-cigarette/Vaping	☐	☐
Smokeless/Chewing tobacco	☐	☐
Difficult extractions	☐	☐
Dentures/Partial Dentures	☐	☐
Dry mouth	☐	☐
Food collection between teeth	☐	☐
Clench or grind your teeth	☐	☐

	Yes	No
Growths/sore spots in your mouth	☐	☐
Gums bleeding, swollen, or tender	☐	☐
Headaches/Migraines	☐	☐
Head/neck pain	☐	☐
Head/neck/jaw trauma or injuries	☐	☐
Jaw pain	☐	☐
If yes, do you have:		
Clicking/popping	☐	☐
Difficulty opening/closing	☐	☐
Difficulty chewing	☐	☐
Jaw surgery	☐	☐
Loose teeth or broken fillings	☐	☐
Mouth breathing	☐	☐

	Yes	No
Marijuana smoking/consumption	☐	☐
Orthodontic Treatment	☐	☐
Oral bisphosphonate treatment (Fosamax, Boniva, etc)	☐	☐
Nitrous Oxide (Laughing gas)	☐	☐
Nightguard/Splint Therapy	☐	☐
Periodontal treatment (deep cleaning, gum grafts, etc)	☐	☐
Pain in any teeth	☐	☐
Speech problems	☐	☐
Sensitivity to pressure	☐	☐
Sensitivity to hot/cold foods	☐	☐
Sensitivity to sweet/sour foods	☐	☐

AUTHORIZATION AND RELEASE

The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. *I also understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am ultimately responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made.* I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me, if I have paid the dental fees incurred. I further understand that a late charge may be added to any overdue balance. If legal action becomes necessary to collect fees due to the office, the undersigned agrees to pay all reasonable costs of such action including attorney's fees and collection costs. *There may be a broken appointment fee if 24-hour notice is not given to reschedule or cancel an appointment.*

Patient/Guardian Signature (Consent) _____ Date _____

FOR OFFICE USE ONLY:

Blood Pressure: _____

Heart Rate: _____

Initials: _____