



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

**DENTAL HISTORY**

Previous Dentist: \_\_\_\_\_ Date of Last Exam: \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

How often do you brush per day? \_\_\_\_\_ per week? \_\_\_\_\_ How often do you floss per day? \_\_\_\_\_ per week? \_\_\_\_\_

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		Yes	No		Yes	No
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	Growths/sore spots in your mouth	<input type="checkbox"/>	<input type="checkbox"/>	Marijuana smoking/consumption	<input type="checkbox"/>	<input type="checkbox"/>
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	Gums bleeding, swollen, or tender	<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Blisters/sores on lips or mouth	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Oral bisphosphonate treatment (Fosamax, Boniva, etc)	<input type="checkbox"/>	<input type="checkbox"/>
Burning sensation on tongue	<input type="checkbox"/>	<input type="checkbox"/>	Head/neck pain	<input type="checkbox"/>	<input type="checkbox"/>	Nitrous Oxide (Laughing gas)	<input type="checkbox"/>	<input type="checkbox"/>
Chewing on tongue/cheek/lip	<input type="checkbox"/>	<input type="checkbox"/>	Head/neck/jaw trauma or injuries	<input type="checkbox"/>	<input type="checkbox"/>	Nightguard/Splint Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Cigarette, pipe, cigar smoking	<input type="checkbox"/>	<input type="checkbox"/>	Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	Periodontal treatment (deep cleaning, gum grafts, etc)	<input type="checkbox"/>	<input type="checkbox"/>
E-cigarette/Vaping	<input type="checkbox"/>	<input type="checkbox"/>	If yes, do you have:			Pain in any teeth	<input type="checkbox"/>	<input type="checkbox"/>
Smokeless/Chewing tobacco	<input type="checkbox"/>	<input type="checkbox"/>	Clicking/popping	<input type="checkbox"/>	<input type="checkbox"/>	Speech problems	<input type="checkbox"/>	<input type="checkbox"/>
Difficult extractions	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty opening/closing	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to pressure	<input type="checkbox"/>	<input type="checkbox"/>
Dentures/Partial Dentures	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty chewing	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to hot/cold foods	<input type="checkbox"/>	<input type="checkbox"/>
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	Jaw surgery	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to sweet/sour foods	<input type="checkbox"/>	<input type="checkbox"/>
Food collection between teeth	<input type="checkbox"/>	<input type="checkbox"/>	Loose teeth or broken fillings	<input type="checkbox"/>	<input type="checkbox"/>			
Clench or grind your teeth	<input type="checkbox"/>	<input type="checkbox"/>	Mouth breathing	<input type="checkbox"/>	<input type="checkbox"/>			

**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: \_\_\_\_\_