Peregrine Family Dentistry, PC

HEALTH HISTORY AND REGISTRATION

PATIENT

Patient Name: Last _____ First_____ Middle Initial_____ Nickname_____
Address: Street _____ City _____ State _____ Zip _____
Home Phone: _____Work Phone: _____ Cell/Pager: _____
Employer: _____ Occupation: _____ E-Mail_____
Sex: M F Birth Date: _____ Marital Status _____ Whom may we thank for referring you to our office? _____
Reason for today's visit _____ Last Dental Visit _____ Prefer Reminders by: ☐Phone ☐Email ☐Text

SPOUSE/PARENT/GUARDIAN INFORMATION

Name: Last _____ First_____ Middle Initial_____ Marital Status:_____
Address: Street _____ City _____ State_____ Zip _____
Home Phone: _____Work Phone: _____ Cell/Pager: _____
Employer: _____ Occupation: _____ E-Mail:_____
Relationship to Patient: _____

DENTAL INSURANCE (PRIMARY CARRIER)

Insured's Name _____
Insurance Co. _____
Insurance Co. Address _____
Insured's Employer _____
Insured's SS/ID # _____
Group _____ Ins Co. Phone _____

SECONDARY (IF APPLIES)

Insured's Name _____
Insurance Co. _____
Insurance Co. Address _____
Insured's Employer _____
Insured's SS/ID # _____
Group _____ Ins 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

Name of Physician:_____ Office Phone:_____ Date of Last Exam:_____

	Yes	No
1. Are you under medical treatment now?.....	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?... If yes, please explain_____	☐	☐
3. Are you taking any medication(s), including non-prescription? If yes, what medication(s) are you taking?_____ _____	☐	☐
4. Do you currently take any blood thinner?.....	☐	☐
5. Have you ever taken Fen-Phen/Redux?.....	☐	☐
6. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?.....	☐	☐
7. Have you taken Viagra, Revati, Cialis or Levitra in the last 24 hours?.....	☐	☐
8. Do you use tobacco?.....	☐	☐
9. Do you drink alcohol?.....	☐	☐
10. Do you smoke/consume marijuana?.....	☐	☐
11. Do you use controlled substances?(ex. narcotics, opioids).....	☐	☐
12. Do you have or have you had any of the following? Please mark all that apply:		

	Yes	No
13. Are you allergic to any of the following?		
Local Anesthetics (e.g. Novocain)……	☐	☐
Penicillin or any other Antibiotics……	☐	☐
Sulfa Drugs……....	☐	☐
Barbiturates……..	☐	☐
Aspirin……..	☐	☐
Sedatives……...	☐	☐
Iodine……	☐	☐
Any Metals (e.g. nickel, mercury, etc.)……	☐	☐
Latex Rubber……	☐	☐
Food/Other (please list) _____		
14. Do you have a persistent cough or throat clearing lasting more than 3 weeks?.....	☐	☐
15. Women only:		
a) Are you pregnant?..……	☐	☐
b) Are you nursing?.....	☐	☐
c) Are you taking contraceptives?.....	☐	☐

☐High Blood Pressure	☐Heart Disease	☐Chest Pains	☐Heart Attack	☐Pacemaker
☐Easily Winded	☐Rheumatic Fever	☐Heart Murmur	☐Swollen Ankles	☐Stroke
☐Hay Fever/Allergies	☐Fainting/Seizures	☐Frequently Tired	☐Tuberculosis	☐Angina
☐Low Blood Pressure	☐Anemia	☐Radiation Therapy	☐Emphysema	☐Asthma
☐Recent Weight Loss	☐Glaucoma	☐Convulsions	☐Cancer	☐Leukemia
☐Arthritis	☐Liver Disease	☐Diabetes	☐Heart Trouble	☐AIDS/HIV
☐Joint Replacement/Implant	☐Kidney Diseases	☐Hepatitis/Jaundice	☐Thyroid Problem	☐STD's
☐Respiratory Problems	☐Stomach Troubles	☐Other_____		

DENTAL HISTORY

Name of Previous Dentist:_____

	Yes	No
1. How often do you brush per day?____ per week?____		
2 How often do you floss per day?____ per week?____		
3. Do your gums bleed while brushing or flossing?.....	☐	☐
4. Are your teeth sensitive to hot or cold liquids/foods?.....	☐	☐
5. Are your teeth sensitive to sweet or sour liquids/foods?.....	☐	☐
6. Do you feel pain in any of your teeth?.....	☐	☐
7. Do you have any sores or lumps in or near your mouth?.....	☐	☐
8. Have you ever experienced any of the following problems in your jaw?		
Clicking……	☐	☐
Pain (joint, ear, side of face)……	☐	☐
Difficulty in opening or closing ……...	☐	☐
Difficulty in chewing……	☐	☐

	Yes	No
9. Do you have frequent headaches?.....	☐	☐
10. Have you had any head, neck, jaw injuries?	☐	☐
11. Do you clench or grind your teeth?.....	☐	☐
12. Do you bite your lips or cheeks frequently?	☐	☐
13. Have you ever had any difficult extractions in the past?.....	☐	☐
14. Have you ever had any prolonged bleeding following extractions?.....	☐	☐
15. Have you had any orthodontic treatment?..	☐	☐
16. Do you wear dentures or partials?.....	☐	☐
If yes, date of placement _____		
17. Have you ever received oral hygiene instructions regarding tooth/gum care?.....	☐	☐

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 a 24 hour notice is not given to reschedule or cancel an appointment.

Patient/Guardian Signature (Consent) _____ Date _____

FOR OFFICE USE ONLY:

Baseline Vitals:_____

Heart Rate:_____

Blood Pressure:_____

Initials:_____