REGISTRATION FORM / MEDICAL-DENTAL HISTORY

Name			Date
Address			Zip Code
Home Phone	Work Phone ☐yes ☐no	Cell Phone	E-mail
I would like to receive correspondences via: ☐ E-mail ☐ Text ☐ Phone Call			
Other Family Members in the Practice		Who referred you to our office?	
SSN	Date of Birth	Marital Status S M D W	Spouse's Name
Occupation		Employer	
If Minor, Name of Guardian		Address & Phone	
Person Responsible for Fee (if other than patient)			Relationship to Patient
Billing Address (if different from above)			
EMERGENCY NOTIFICATION Nearest Relative Not Living With You - Name & Phone			

***Please answer ALL questions (eg. Yes, No, or N/A) and circle if necessary. This information will be held in strict confidence (re: HIPAA Policies).**

MEDICAL HISTORY

Family physician name, address, and phone_____

Specialist physician name, address, and phone _____

Date of your last visit to a doctor _____ Purpose of visit _____

Has there been any change in your general health in the past year? _____ If yes, describe _____

Have you ever had a major operation or been hospitalized?_____ If yes, describe_____

Have you ever had a serious injury to your head or neck? _____ If yes, describe _____

Do you have or have you ever been exposed to tuberculosis? _____ If yes, describe _____

Have you ever had an orthopedic joint replacement? _____ If yes, describe _____

Have you ever had radiation therapy or chemotherapy for a growth, tumor, cancer, or other condition? _____

Do you take steroids now or have you in the last two years (eg. cortisone, prednisone)? _____

Have you ever taken oral or IV bisphosphonates (Fosamax, Boniva, Actonel, Zometa, or Aredia)? _____

Have you ever taken illegal drugs?_____ If yes, describe what drugs and when taken_____

Do you smoke or use tobacco? _____ If yes, type & amount _____

Do you drink alcoholic beverages?_____ If yes, # / day or week_____

Are you currently, or have you been in the past, alcohol or drug dependent? _____ If yes, describe _____

Are you HIV-positive or do you have AIDS?_____If yes, describe _____

Do you now have, or have you had, a sexually transmitted disease? _____ If yes, describe _____

Have you ever had, or do you now have, hepatitis or cirrhosis?_____ If yes, describe_____

Have you been treated by a psychiatrist or counselor?_____ If yes, describe _____

For females: Are you taking birth control pills? _____ Are you taking hormone replacement? _____

Are you pregnant? _____If yes, number of weeks? _____Are you nursing? _____

Are you taking any drugs or medications?_____ If yes, list the dosage and purpose of each _____

_____ _____

_____ _____

_____ _____

Have you ever had an allergic reaction to a medication? _____ If yes, describe _____

Are you allergic to any of the following: Penicillin, local anesthetics, aspirin, metals/jewelry, latex, other? _____

HAVE YOU EVER HAD OR BEEN TREATED FOR:

Rheumatic fever, rheumatic heart disease, congenital heart disease, heart murmur, mitral valve prolapse, artificial heart valve, or endocarditis?

Coronary heart disease, angina, heart attack, heart surgery, a pacemaker, irregular beats, or congestive heart disease? _____

High/low blood pressure, anemia, blood clots, leukemia, lymphoma, or bleeding disorders? _____

Stomach or intestinal disease, acid reflux, ulcers, or Crohn's disease? _____

Asthma, tuberculosis, emphysema, COPD, sleep apnea, or hay fever? _____

Cancer, a growth, or tumor? _____

TIA, stroke, seizures, fainting spells, or dementia? _____

Diabetes or thyroid disease? _____ Kidney problems or renal dialysis? _____

Arthritis, rheumatism, osteoporosis, TMJ disorders, or fibromyalgia? _____

Do you have any other problem, disease, or condition not listed above? _____

DENTAL HISTORY

What is the reason for your visit today? _____

What is the chief complaint of your teeth or mouth? _____

Is there anything that you would like done to enhance your smile? _____

Date of your last visit to a dentist _____ Reason for your last visit _____

In respect to any previous dental treatment, have you had an allergic reaction or ever fainted? _____

Have you had any problems associated with previous dental treatment? _____ If yes, describe _____

Are you currently experiencing any dental pain or discomfort? _____

Are any teeth sensitive to heat, cold, or pressure? _____

Do you have any swelling on or around your face or neck? _____

Do you have any loose teeth, or have your teeth shifted or flared, creating spaces? _____

Have you ever been diagnosed or treated for periodontal (gum) disease? _____

Do your gums bleed when brushing or flossing? _____ Does food catch between your teeth? _____

Do you grind your teeth or clench your jaw? _____

Do you have any headaches, earaches, or neck pain? _____ Do you have pain or clicking in the jaw joint or TMJ? _____

Are there any sores or growths in your mouth? _____

Have you ever had a serious injury to your head or mouth? _____

Do you have a history of oral surgery, implants, cosmetic procedures, or TMJ surgery? _____

Have you ever had orthodontic treatment (braces)? _____

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

Is your mouth dry? _____ Do you drink bottled water? _____ If yes, how often? _____

Which of the following do you consume more than once per day: candy/mints, gum, coffee/tea with sugar, soda pop, sports drinks, cough drops, or other foods high in sugar? _____

Rate your apprehension of dental treatment on a scale of 0 (relaxed) to 10 (extreme apprehension) _____

To the best of my knowledge, the above questions have been accurately answered.

Signature _____ Date _____

Dentist's Review