Health History & Registration

Patient Information

Patient's Name: Last _____ First _____ Middle Initial _____
Sex: M F Birth Date _____ Age _____ Today's Date _____
Who may we thank for referring you to our office? _____ Reason for this visit _____

Responsible Party Information

Name: Last _____ First _____ Middle Initial _____ Marital Status _____
Residence Street _____ Apt # _____ City _____ State _____ Zip _____
Mailing Address Street _____ Apt # _____ City _____ State _____ Zip _____
How long at this address _____ Home Phone _____ Cell Phone _____
Work Phone _____ E-Mail _____
Birth date _____ Relation to Patient _____
Employer _____ Occupation _____ No. Years Employed _____

Responsible Party's Spouse

Name _____
Last First MI
Employer _____ Occupation _____
Birth Date _____
Home Ph. _____ Cell Ph. _____
Work Ph. _____ E-Mail _____

Emergency Information: Relative Not Living With You

Name _____
Last First
Relationship _____
Address _____City, State _____
Home Ph. _____ Cell Ph. _____
Work Ph. _____

Dental Insurance Information (Primary Carrier)

Insured's Name _____
Insurance Co. _____
Insurance Co. Address _____
Insured's Employer _____
Group # _____ Local # _____

Secondary Dental Coverage Information (if applicable)

Insured's Name _____
Insurance Co. _____
Insurance Co. Address _____
Insured's Employer _____
Group # _____ Local # _____

Dental History

How long since you have been to a dentist? _____ Date of last complete dental exam _____
Last full mouth set of x-rays (~18 x-rays) _____ Last panoramic x-ray (one large x-ray of entire mouth) _____
Are you having problems now? Y N *If yes please explain* _____
Do you think your present dental health is poor? Y N
Do you wear dentures (partials or full)? Y N *If yes, are you happy with them?* Y N *If no, please explain* _____
Would you like to know more about permanent replacements (implants)? Y N
Are you apprehensive about dental treatment? Y N
Have you had any periodontal (gum) treatments? Y N
Do your gums bleed, feel tender, or irritated? Y N
Are your teeth sensitive to hot, cold, sweets, or pressure? Y N
Are you aware of grinding or clenching your teeth? Y N *If yes, do you wear or have you ever worn an appliance to protect your teeth? Y N*
Do you have headaches, earaches, or neck pains? Y N
Have you ever had braces (orthodontics)? Y N *If yes, do you still wear retainers? Y N*
Do you have discolored teeth that bother you? Y N
Would you like your smile to look better or different? Y N
Do you regularly use dental floss? Y N

Name of previous dentist: _____ City: _____ State: _____
How do you feel about your teeth? _____
Please rank the following in the order in which they would keep you from having dental treatment:
Fear of pain # _____ Cost of treatment # _____ Lack of concern # _____ Time (missing work) #_____

Patient signature _____ Date _____ Dentist signature _____

Medical History

Patient name: _____ Date of birth: _____

Primary physician: _____ Specialists: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Y N *If yes please explain*: _____

Have you ever been hospitalized or had a major operation? Y N *If yes please explain*: _____

Have you ever had a serious head or neck injury? Y N *If yes please explain*: _____

Are you taking any medications, pills, drugs, supplements or vitamins? *If yes please explain*: _____

_____

Do you take or have you taken Phen-Fen or Redux? Y N

Do you take or have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Y N

If yes, when and please explain: _____

Are you on a special diet? *Y N If yes, please explain*: _____

Do you use or have you ever used tobacco? Y N *If yes, how long have you/did you use tobacco and how much?* _____

Do you use or have you ever used controlled substances? Y N *If yes, please explain* _____

Women are you:
Pregnant/trying to get pregnant? Y N Taking oral contraceptives? Y N Nursing? Y N

Are you allergic to any of the following?
Aspirin Y N Penicillin Y N Codeine Y N Local Anesthetics Y N Acrylic Y N Metal Y N Latex Y N Sulfa Drugs Y N
Other Y N If yes please explain: _____

Do you have, or have you had any of the following?

Acid Reflux/Heartburn Y N	Depression/ Anxiety Y N	Hepatitis B or C Y N	Rheumatic Fever Y N
AIDS/ HIV Positive Y N	Diabetes Y N	Herpes Y N	Rheumatism Y N
Alzheimer's Disease Y N	Drug Addiction Y N	High Blood Pressure Y N	Scarlet Fever Y N
Anaphylaxis Y N	Easily Winded Y N	High Cholesterol Y N	Seasonal Allergies Y N
Anemia Y N	Emphysema Y N	Hives or Rash Y N	Shingles Y N
Angina Y N	Epilepsy or Seizures Y N	Hypoglycemia Y N	Sickle Cell Disease Y N
Arthritis/ Gout Y N	Excessive Bleeding Y N	Immunizations Y N	Sinus Trouble Y N
Artificial Heart Valve Y N	Excessive Thirst Y N	Irregular Heartbeat Y N	Spina Bifida Y N
Artificial Joint Y N	Fainting Spells/ Dizziness Y N	Kidney Problems Y N	Stomach/Intestinal Disease Y N
Asthma Y N	Frequent Cough Y N	Leukemia Y N	Stroke Y N
Blood Disease Y N	Frequent Diarrhea Y N	Liver Disease Y N	Swelling of Limbs Y N
Blood Transfusion Y N	Frequent Headaches Y N	Low Blood Pressure Y N	Thyroid Disease Y N
Breathing Problem Y N	Genital Herpes Y N	Lung Disease Y N	Tonsillitis Y N
Bruise Easily Y N	Glaucoma Y N	Mitral Valve Prolapse Y N	Tuberculosis Y N
Cancer Y N	Hay Fever Y N	Osteoporosis Y N	Tumors or Growths Y N
Chemotherapy Y N	Heart Attack/Failure Y N	Pain in Jaw Joints Y N	Ulcers Y N
Chest Pains Y N	Heart Murmur Y N	Parathyroid Disease Y N	Venereal Disease Y N
Cold Sores/ Fever Blisters Y N	Heart Pacemaker Y N	Psychiatric Care Y N	Yellow Jaundice Y N
Congenital Heart Disorder Y N	Heart Trouble/ Disease Y N	Radiation Treatments Y N	
Convulsions Y N	Hemophilia Y N	Recent Weight Loss Y N	
Cortisone Medicine Y N	Hepatitis A Y N	Renal Dialysis Y N	

Have you ever had any serious illness not listed above? Y N _____

Comments:_____

_____

Permission to release heath information:

I grant the right to Dr. Elberty to release health information obtained from me, and information about my dental treatment to third party payers (my insurance company) and/or other health practitioners.

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, parent, or guardian _____ Date _____