Patient Number _____ A B C HEALTH HISTORY & REGISTRATION

PATIENT INFORMATION

PATIENT'S NAME Last_____ First_____ Middle Initial_____ SEX: M F BIRTHDATE_____ AGE_____

If patient is a Minor, give Parent's or Guardian's Name _____ Reason for this visit_____

Who may we thank for referring you to our office?_____ TODAY'S DATE_____

RESPONSIBLE PARTY INFORMATION

NAME Last_____ First_____ Middle_____ MARITAL STATUS_____

RESIDENCE Street_____ City_____ State_____ Zip_____

MAILING ADDRESS Street_____ City_____ State_____ Zip_____

HOW LONG AT THIS ADDRESS_____ HOME PHONE _____ WORK PHONE _____

PREVIOUS ADDRESS (if less than 3 yrs.) Street _____ City_____ State_____ Zip_____

SOCIAL SECURITY #_____ BIRTHDATE_____ DRIVER'S LICENSE #_____ RELATION TO PATIENT_____

EMPLOYER_____ OCCUPATION_____ NO. YEARS EMPLOYED_____

RESPONSIBLE PARTY'S SPOUSE

NAME_____

EMPLOYER_____ NO. YEARS EMPLOYED____

OCCUPATION_____ SOC. SEC. #_____

WORK PHONE _____ BIRTHDATE_____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME_____

ADDRESS _____

CITY, STATE_____ PHONE_____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co._____

Insurance Co. Address_____

Insured's Employer _____

Insured's Soc. Sec. #_____ Group#_____ Local#_____

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name _____

Insurance Co._____

Insurance Co. Address_____

Insured's Employer _____

Insured's Soc. Sec. #_____ Group#_____ Local#_____

It is important that I know about your Medical and Dental Historye facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this qestionnaire.

DENTAL HISTORY	YES	NO
HOW LONG SINCE you have seen a Dentist?		
Last COMPLETE Dental Exam, DATE:		
Last FULL MOUTH X-RAYS, DATE:		
Are you having PROBLEMS now?	❑	❑
WHAT?		
Is your present dental health POOR?	❑	❑
Do you wear DENTURES (Partials or Full)	❑	❑
Are you UNHAPPY with your dentures?	❑	❑
Would you like to know more about PERMANENT REPLACEMENTS?	❑	❑
Are you APPREHENSIVE about dental treatment?	❑	❑
Have you had any PERIODONTAL (GUM) treatments?	❑	❑
Do your gums BLEED, or feel TENDER or IRRITATED?	❑	❑
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	❑	❑
Are you UNHAPPY with the APPEARANCE of your teeth?	❑	❑
Are you aware of GRINDING or CLENCHING your teeth	❑	❑
Do you have HEADACHES, EARACHES, or NECK PAINS?	❑	❑
Have you worn BRACES on your teeth? (ORTHODONTICS)	❑	❑
Do you have DISCOLORED teeth that bother you?	❑	❑
Would you like your smile to LOOK BETTER or DIFFERENT?	❑	❑
Do you REGULARLY use DENTAL FLOSS?	❑	❑
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	#	LACK of concern	#
COST of treatment	#	MISSING work time	#

MEDICAL HISTORY	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	❑	❑
Are you under a PHYSICIAN'S CARE now?	❑	❑
For What?		
What MEDICATIONS are you currently taking?		
Are you PREGNANT?	❑	❑
Do you SMOKE?	❑	❑

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

Heart Disease or Attack	A.I.D.S./A.R.C./HIV Pos.	Bruise Easily
Angina Pectoris	Hepatitis A (infectious)	Emphysema
High Blood Pressure	Hepatitis B (serum)	Tuberculosis
Heart Murmur	Liver Disease	Asthma
Rheumatic Fever	Blood Transfusion	Hay Fever
Congenital Heart Lesions	Drug Addiction	Sinus Trouble
Mitral Valve Prolapse	Hemophilia (Bleeding Problems)	Allergies of Hives
Artificial Heart Valve	Fever Blisters	Diabetes
Heart Pacemaker	Epilepsy or Seizures	Thyroid Disease
Heart Surgery	Nervousness	Radiation Treatment
Artificial Joints (Hip, Knee)	Psychiatric Treatment	Arthritis
Anemia	Glaucoma	Cortisone Medicine
Stroke	Chemotherapy (Cancer, Leukemia)	Pain in Jaw Joints
Kidney Trouble	Venereal Disease	Alcoholism
Ulcers	(Syphilis, Gonorrhea, etc.	Cosmetic Surgery

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin	Local Anesthetic	Erythromycin
Nitrous Oxide	Codeine	Penicillin

Are you aware of being allergic to any other medications or substances?_____

If yes, please list:_____

Is there any other Medical or Dental information that you feel I should know about?

_____

FAMILY PHYSICIAN_____ PHONE NO._____

PATIENT Signature (Parent of Child)_____ Date:_____ DENTIST Signature_____