Prefers To Be Called _____

HEALTH HISTORY & REGISTRATION

Name _____ Birthdate _____ Sex _____ Today's Date _____

Home Address _____ City _____ State _____ Zip _____

Please Circle One: Single, Married, Separated, Divorced, Widowed, Child Home Phone Number _____

Name of Spouse (Parent if Minor) _____ Person Responsible for Account _____

Your Employer _____ Your Soc. Sec. # _____ Work Phone _____

Spouse's Employer _____ Spouse's Soc. Sec. # _____ Work Phone _____

Referred to us by _____ Name & Address of a Relative Not living with you _____

Reason for this visit _____

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 # MISSING work time #

INSURANCE INFORMATION

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

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

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

It is important that I know about your Medical and Dental History. These 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 questionnaire.

* DENTAL HISTORY *

Last COMPLETE Dental Exam, Date: _____

Last FULL MOUTH X-RAYS, Date: _____

(Machine that rotates around your head, or 16 small films.)

YES Are you having PROBLEMS now? NO
WHAT? _____

YES Has your Dental Care been IRREGULAR in the last 5 years? NO
YES Are you troubled with BAD-BREATH? NO
YES Does food usually WEDGE between certain teeth? NO
WHERE? _____

YES Do your gums BLEED, or feel TENDER or IRRITATED? NO
YES Do you have LOOSE, TIPPED or SHIFTING teeth? (circle) NO
YES Have you had any PERIODONTAL (GUM) treatments? NO
YES Are your teeth sensitive to HOT, COLD, SWEETS, PRESSURE? (circle) NO
YES Are you UNHAPPY with the APPEARANCE of your teeth? NO
YES Have you worn BRACES on your teeth? (ORTHODONTICS) NO
YES Are you aware of GRINDING, or CLENCHING your teeth? NO
YES Are your jaws or teeth SORE when you awake from sleep? NO
YES Do you have HEADACHES, EARACHES, or NECK PAINS? NO
YES Have you LOST any teeth, other than wisdom teeth? NO
YES Do you have problems with teeth/fillings BREAKING? NO
YES Do you REGULARLY use DENTAL FLOSS? NO
YES Would you like us to help you learn proper methods of Home Care, so you can stop dental problems in your mouth? NO
YES Are you APPREHENSIVE about dental treatment? NO

How do you feel about your teeth? _____

* MEDICAL HISTORY *

YES Do you have any CURRENT HEALTH PROBLEMS? NO
YES Are you under a PHYSICIAN'S CARE now? NO
For What? _____

Have you had any of the following?

YES Rheumatic Fever/Heart Murmur? NO
YES Any type of HEART PROBLEMS? NO
YES High Blood Pressure? NO
YES Diabetes? NO
YES Fainting Spells, Seizures, or Epilepsy? NO
YES Asthma, or any Respiratory Problems? NO
YES Hepatitis, or any Liver Damage? NO
YES Excessive Bleeding? NO
YES Blood problems, Leukemia, Anemia? NO
YES Kidney Problems? NO
YES Arthritis, Sore Joints? NO
YES Venereal Disease, A.I.D.S.? NO
YES Are you on a prescribed diet? NO
YES Surgery: For What? NO

YES Are you PREGNANT? Due Date? NO

Are You ALLERGIC TO:

YES Penicillin or other antibiotics? NO
YES Codeine? NO
YES Aspirin? NO
YES Novocaine? NO
YES Other drugs? NO
YES Are you taking MEDICATIONS now? NO
Name Them: _____

FAMILY PHYSICIAN: _____ PHONE NO. _____

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

PATIENT'S SIGNATURE _____ DATE: _____
PARENT (IF CHILD)

DENTIST'S SIGNATURE _____ DATE: _____

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