# PATIENT REGISTRATION & MEDICAL/DENTAL HISTORY

**Medical Alert**

Pharmacy Name_____ Phone_____

So that we may provide you with the best possible care, please complete both sides of this medical/dental history form.

(PLEASE PRINT)

Date_____ Whom may we thank for referring you?_____

Patient Name_____ Patient Is ☐ Policy Holder ☐ Responsible Party (Preferred Name_____)

Home Phone_____ Work Phone_____ Cell/Pager_____ Email_____

Address_____

City_____ State_____ Zip_____ Social Security #_____ Driver's Lic.#_____

Sex: ☐ Male ☐ Female Age_____ Birthday ___/___/___ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed By_____

Occupation_____

Business Address_____

City_____ State_____ Zip_____ Tel_____

Spouse Name_____ Birthday ___/___/___

Employed By_____

Business Address_____

City_____ State_____ Zip_____ Tel_____

Social Security #_____

**Person Responsible For Account**

Name:_____ Relation:_____

Billing Address:_____

_____

Hm# (  )_____ DL#_____

Employer:_____

Wk# (  )_____ Ext:_____ SS#_____

In case of emergency, who should be notified?_____ Tel_____

## *Dental Insurance Primary Carrier*

Insured's Name | Social Security #

Insurance Company | Telephone

Address

City | State | Zip

Group Number | ID Number | Birthdate

Insured's Employer

## *Dental Insurance Secondary Carrier*

Insured's Name | Social Security #

Insurance Company | Telephone

Address

City | State | Zip

Group Number | ID Number | Birthdate

Insured's Employer

## DENTAL HISTORY

Circle "Yes" or "No" to each item.

**Do you:**

| | | |
|---|---|---|
| Clench or grind your teeth while awake or asleep? | Yes | No |
| Bite your lips or cheeks regularly? | Yes | No |
| Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) | Yes | No |
| Mouth breathe while awake or asleep? | Yes | No |
| Have tired jaws, especially in the morning? | Yes | No |
| Smoke/chew tobacco? | Yes | No |
| How much?_____ | | |

**Have you ever had:**

| | | |
|---|---|---|
| Orthodontic treatment? | Yes | No |
| Oral surgery? | Yes | No |
| Periodontal treatment? | Yes | No |
| A bite plate or mouth guard? | Yes | No |
| Your teeth ground or the bite adjusted? | Yes | No |
| A serious injury to the mouth or head? | Yes | No |

If yes, please describe, including cause.

_____

**Are any of your teeth sensitive to:**

| | | |
|---|---|---|
| Hot or cold | Yes | No |
| Sweet | Yes | No |
| Biting or chewing | Yes | No |
| Have you noticed any mouth odors or bad tastes? | Yes | No |
| Do you frequently get cold sores, blisters or any other oral lesions? | Yes | No |
| Do your gums bleed or hurt? | Yes | No |
| Have your parents experienced gum disease or tooth loss? | Yes | No |
| Have you noticed any loose teeth or a change in your bite? | Yes | No |
| Do you have difficulty in chewing on either side of the mouth? | Yes | No |
| Does food tend to become caught in between your teeth? | Yes | No |

If yes, where?_____

_____

**Have you ever experienced:**

| | | |
|---|---|---|
| Clicking or popping of the jaw? | Yes | No |
| Pain? (joint, ear, side of face) | Yes | No |
| Difficulty in opening or closing the mouth? | Yes | No |
| Headaches, neckaches or shoulder aches? | Yes | No |
| Sore muscles (neck, shoulders)? | Yes | No |
| Are you happy with your smile? | Yes | No |
| Are you pleased with the color of your teeth? | Yes | No |
| Would you like to keep all of your teeth all of your life? | Yes | No |
| Do you feel nervous about having dental treatment? | Yes | No |

If yes, what is your biggest concern?

_____

_____

| | | |
|---|---|---|
| Have you ever had an upsetting dental experience? | Yes | No |

If yes, please describe_____

_____

# MEDICAL HISTORY

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? ○ Yes ○ No If yes, please explain:_____

Physician Name_____ Phone_____

Have you ever been hospitalized or had a major operation? ○ Yes ○ No Do you use tobacco? ○ Yes ○ No

Have you ever had a serious head or neck injury? ○ Yes ○ No Do you use controlled substances? ○ Yes ○ No

Are you taking any medications, pills, or drugs? ○ Yes ○ No If answer is yes to any of these, please explain:_____

Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No _____

Have you ever taken bisphosponates (ex. Aredia/Fosamax)? ○ Yes ○ No _____

Are you on a special diet? ○ Yes ○ No _____

**Women: Are you**

Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain:_____

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

| | | | |
|---|---|---|---|
| AIDS/HIV Positive or Other ○ Yes ○ No | Convulsions ○ Yes ○ No | Hepatitis A ○ Yes ○ No | Scarlet Fever ○ Yes ○ No |
| Alzheimer's Disease ○ Yes ○ No | Cortisone Medicine ○ Yes ○ No | Hepatitis B or C ○ Yes ○ No | Shingles ○ Yes ○ No |
| Anaphylaxis ○ Yes ○ No | Diabetes ○ Yes ○ No | Herpes ○ Yes ○ No | Sickle Cell Disease ○ Yes ○ No |
| Anemia ○ Yes ○ No | Drug Addiction ○ Yes ○ No | High Blood Pressure ○ Yes ○ No | Sinus Trouble ○ Yes ○ No |
| Angina Pectoris ○ Yes ○ No | Easily Winded ○ Yes ○ No | Hives or Rash ○ Yes ○ No | Special Diet ○ Yes ○ No |
| Arthritis/Gout/Rheumatism ○ Yes ○ No | Emphysema ○ Yes ○ No | Hypoglycemia ○ Yes ○ No | Spina Bifida ○ Yes ○ No |
| Artificial Heart Valve(s) ○ Yes ○ No | Epilepsy or Seizures ○ Yes ○ No | Irregular Heartbeat ○ Yes ○ No | Stomach/Intestinal Disease ○ Yes ○ No |
| Artificial Joint(s) ○ Yes ○ No | Excessive Bleeding ○ Yes ○ No | Kidney Problems ○ Yes ○ No | Stroke ○ Yes ○ No |
| Aspirin Taken Daily ○ Yes ○ No | Excessive Thirst ○ Yes ○ No | Leukemia ○ Yes ○ No | Swelling of Limbs ○ Yes ○ No |
| Asthma ○ Yes ○ No | Fainting Spells/Dizziness ○ Yes ○ No | Liver Disease ○ Yes ○ No | Swollen Neck Glands ○ Yes ○ No |
| Back Problems ○ Yes ○ No | Frequent Cough ○ Yes ○ No | Low Blood Pressure ○ Yes ○ No | Thyroid Disease ○ Yes ○ No |
| Blood Disease ○ Yes ○ No | Frequent Diarrhea ○ Yes ○ No | Lung Disease ○ Yes ○ No | Tonsillitis ○ Yes ○ No |
| Blood Transfusion ○ Yes ○ No | Frequent Headaches ○ Yes ○ No | Mitral Valve Prolapse ○ Yes ○ No | Tuberculosis ○ Yes ○ No |
| Breathing Problem ○ Yes ○ No | Genital Herpes ○ Yes ○ No | Pain in Jaw Joints ○ Yes ○ No | Tumors or Growths ○ Yes ○ No |
| Bruise Easily ○ Yes ○ No | Glaucoma ○ Yes ○ No | Parathyroid Disease ○ Yes ○ No | Ulcers ○ Yes ○ No |
| Cancer ○ Yes ○ No | Hay Fever ○ Yes ○ No | Psychiatric Care ○ Yes ○ No | Venereal Disease ○ Yes ○ No |
| Chemotherapy ○ Yes ○ No | Heart Attack/Failure ○ Yes ○ No | Radiation Treatments ○ Yes ○ No | Yellow Jaundice ○ Yes ○ No |
| Chest Pains ○ Yes ○ No | Heart Murmur ○ Yes ○ No | Recent Weight Loss ○ Yes ○ No | |
| Circulatory Problems ○ Yes ○ No | Heart Pace Maker ○ Yes ○ No | Renal Dialysis ○ Yes ○ No | |
| Cold Sores/Fever Blisters ○ Yes ○ No | Heart Trouble/Disease ○ Yes ○ No | Rheumatic Fever ○ Yes ○ No | |
| Congenital Heart Disorder ○ Yes ○ No | Hemophilia ○ Yes ○ No | Rheumatism ○ Yes ○ No | |

Have you ever had any serious illnesses not listed above? ○ Yes ○ No If yes, please explain:_____

Do you wear contact lenses? ○ Yes ○ No Do you have high cholesterol? ○ Yes ○ No

Have you ever responded adversely to medical or dental treatment? ☐ Yes ☐ No If Patient is a child what is his/her weight?_____

Have you ever been advised to be pre-medicated prior to any dental procedure? ☐ Yes ☐ No Have you had a recent transfusion? ☐ Yes ☐ No

Is there anything else we should know about your medical history?_____

Comments:_____

Date of last dental cleaning/exam?_____

I verbally reviewed the medical / dental information above with the parent / guardian & patient named herein. _____

Staff / Dr.'s Initials Date

## AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient (or parent if minor)

Doctor's Comments_____