PATIENT REGISTRATION AND MEDICAL HISTORY

MEDICAL ALERT

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form.
(PLEASE PRINT)

Date_________________

Patient ____ Social Security #____________________

Last Name *First Name* *Initial* *Preferred Name*

Street Address:___________________________________ City:________________________ State:_____________ Zip__________

Sex___ M ___ F Age _____________ Birthdate __________________________ __Single __Married __Widowed __ Separated __Divorced

Home Phone__________________________ E-mail Address _________________________________ Cell Phone_______________________

Employed by ____ Occupation_____________________________

Business Address ____ Business Phone_____________________________

Spouse Name _____________________________________ Spouse Social Sec # ___________________ Spouse birthdate ________________

Spouse Employed by ____ Spouse Occupation ____

Who is responsible for this account? ______________________________________ Relationship to patient____________________

Responsible Party's Social Security# _______________________Employer________________________ Emp. Phone_____________________

Dental Insurance Primary Carrier

Insured's Name ____

Insurance Company ____

Insurance Co. Address ______________________________________

____

Insured's Employer ____

Insured's Soc. Sec. # ____

Group #________________________ID# ______________________

Dental Insurance Secondary Carrier

Insured's Name ____

Insurance Company ____

Insurance Co. Address ______________________________________

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Insured's Employer ____

Insured's Soc. Sec. # ____

Group #________________________ID# ______________________

In case of emergency, who should be notified? ____ Phone # ____________________________

Whom may we thank for referring you? ____

MEDICAL HISTORY

Physician's Name ____ Date of Last Physical ________________________________

Have you ever had any of the following? (check the ones that apply):

__Heart Disease or Attack	__Epilepsy/Seizures	__Artificial Heart Valves	__Respiratory Disease	__Glaucoma	__Ulcer
__Heart Murmur	__Artificial Joints	__Tuberculosis	__Swollen Neck Glands	__Diabetes	
__Heart Pacemaker	__Stroke	__AIDS/HIV	__Rheumatic Fever	__Radiation treatment	
__Mitral Valve Prolapse	__Hepatitis	__Jaundice	__Liver Disease	__General Allergies	
__Kidney trouble	__Sinus Problems	__Angina Pectoris	__Cancer	__Leukemia	
__Blood Disease	__Thyroid Disease	__Allergies to Anesthetics	__High Blood Pressure	__Low Blood pressure	
__Circulatory Problems	__Nervous Problems	__Chemical Dependency	__Venereal Disease	__Psychiatric Care	
__Back Problems	__Chronic Diarrhea	__Blood transfusion	__Arthritis	__Hemophilia	

Do you have drug allergies or have you ever had an adverse reaction to any medication?____________ If so what ______________________

____

Have you ever responded adversely to medical or dental treatment? ____

Are you taking any medication at this time?______________ If so, what ____

Are you under the care of a physician?_________ For what conditions? ____

If patient is a child, what is his/her weight? ____

(Women) Do you suspect that you are pregnant?_________ How far along? _______________________ Are you nursing? ______________

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

____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits to which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: ____ Date: ___________________________

What is the reason for your visit today? ____

____

Date of Last dental Visit______________________ Last dental Cleaning_______________________ Last Full mouth X-ray_____________

What was done at your last dental visit? ____

____

Previous Dentist's Name ____

Address ____

Telephone ____________________________ How often do you have dental examinations? _______________________________

How often do you brush? ___________________________________How often do you floss? ___________________________________

What other dental aids do you use?(toothpick,ect)____

Do you have any dental problems now? YES No If yes describe:____

____

Are any of your teeth sensitive to:

Hot or cold? Yes No

Sweets? Yes No

Biting or Chewing Yes No

Have you noticed any mouth odors or bad taste? 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 change In your bite? Yes No

If yes, where? __________________________________

Do You:

Clench or grid your teeth while awake or asleep? Yes No

Bite your lips or cheeks regularly? Yes No

Hold foreign objects with your teeth? (pencils, pipes, pins, nails, fingernails) Yes No

Mouth breath while awake or asleep? Yes No

Smoke/ chew tobacco? Yes No

Have you ever had:

Orthodontic treatment? Yes No

Oral surgery? Yes No

Periodontal treatment? Yes No

Your teeth ground or the bite adjusted? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head Yes No

If so, please describe, including cause _________

____

Have you 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, neck aches or shoulder aches? Yes No

Sore muscles (neck, shoulders)? Yes No

Are you satisfied with your teeth's appearance? Yes No

Would you like to keep all your teeth all your life? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern?

____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe _______________

____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe ____

____

____

FINANCIAL POLICY

If you have insurance, as a courtesy to our patients we will gladly file the insurance. We allow 30 days for the insurance company to pay the balance of your account. If we have not received total payment from your insurance company within that period, you are responsible for the full balance at the time.

CANCELLATION POLICY

If you are unable to keep a scheduled appointment kindly give 24 hours notice or a charge will be made for time reserved.

PAYMENT POLICY

I agree to be responsible for the payment of all services rendered on my half or my dependants. I understand that payment is due at time of service unless other arrangements have made. In the payments are not received by the agreed upon dates, I understand that additional charges incurred through collections efforts and/ or attorney fees may be added to my account.

_______________________________________ _____________________

Patient Signature Date

_______________________________________ _____________________ _____________________

Parent or Responsible Party Relationship to Patient Date