PATIENT HEALTH HISTORY

PATIENT'S NAME Last________________________ First_________________________ Middle initial____

MEDICAL HISTORY

Today's Date_________

What tobacco products do you use? ______ ____________________

Any heart problems?:

____

List current medications

____

Allergies: **Latex** *yes no* **Metal** or **Costume jewelr**y *yes no*

List any **drug** or **medication** allergies:

____

Please check which of the following you have presently, or have had in the past:

	Yes	No		Yes	No
AIDS/HIV pos	☐	☐	Heart Problems	☐	☐
Anemia	☐	☐	Hemophilia	☐	☐
Arthritis	☐	☐	Herpes	☐	☐
Artificial heart valves	☐	☐	Hepatitis	☐	☐
Artificial joints	☐	☐	High Blood Pressure	☐	☐
Asthma	☐	☐	Kidney Disease	☐	☐
Autoimmune disease	☐	☐	Liver Disease	☐	☐
Back Problems	☐	☐	Mitral Valve Prolapse	☐	☐
Blood Disease	☐	☐	Pacemaker	☐	☐
Cancer	☐	☐	Psychiatric Care	☐	☐
Chemotherapy	☐	☐	Radiation Treatment	☐	☐
Circulatory Problems	☐	☐	Respiratory Disease	☐	☐
Cortisone Treatments	☐	☐	Shingles	☐	☐
Cough *(persistent or bloody)*	☐	☐	Spina Bifida	☐	☐
Diabetes	☐	☐	Stroke	☐	☐
Epilepsy	☐	☐	Thyroid Disease	☐	☐
Fainting	☐	☐	Tuberculosis	☐	☐
Food Allergies	☐	☐	Ulcer	☐	☐
Glaucoma	☐	☐	Venereal Disease	☐	☐
Headaches	☐	☐	Currently Pregnant?	☐	☐
Heart Murmur	☐	☐			

Any disease or problem not listed:

____

Name of Family Physician:

____

DENTAL HISTORY

How long since you've seen a dentist?

____

Name and city of previous dentist:

____

Check yes or no:	YES	NO
Are you aware of any current problems?	_____	_____
Do your gums bleed or feel tender?	_____	_____
Have you been treated for gum disease?	_____	_____
Has anyone in your family had gum disease?	_____	_____
Do you regularly floss?	_____	_____
Are your teeth sensitive to *cold*, *hot* or *sweets*?	_____	_____
Have you ever had a toothache?	_____	_____
Do you like the way your smile looks?	_____	_____
Have you worn braces?	_____	_____
Do you have discolored teeth that bother you?	_____	_____
Do you have dentures or partials?	_____	_____
Do you grind or clench your teeth?	_____	_____
Do you have morning headaches or jaw pain?	_____	_____

Please describe your dental needs:

Circle the choice you most agree with:

1. Healthy, attractive teeth require commitment. My feelings about my teeth are:
   a. very high priority– I'll do whatever it takes to keep my teeth forever
   b. somewhat important– I'll take fairly good care of them
   c. less important– I don't want to spend lots of time on my teeth
2. I consider my fear of dentistry to be:
   a. High– I may require sedation for extensive treatment
   b. Moderate– I'm nervous but don't want drugs or gas
   c. Low—I actually enjoy dental cleanings
3. Of the following, my main reason for delaying dental treatment would be:
   a. Lack of Time
   b. Cost
   c. Lack of Concern

____
Patient Signature and Date

____
Dentist Signature and Date

PATIENT REGISTRATION

PATIENT'S NAME Last__________________First________________Middle initial__SEX: M F AGE__Birthdate________
Social Security#________________________For Minors, Parent's or Guardian's Name________________________
Occupation__________________________How did you hear about us?____________________________________

RESPONSIBLE PARTY INFORMATION

NAME LAST________________________FIRST________________________Middle Initial___ Marital Status____________
ADDRESS Street____City______________State___Zip_____________
PHONES Home_____________Work______________Cell Phone____________E-mail__________________________
Social Security________________Birthdate______________Relation to patient______________________
Employer______________________Occupation____________________Spouse name______________________________
Insurance Company____

EMERGENCY CONTACT

NAME Last________________________________First____________________Relationship____________________
Phones
Home__________________Work__________________Cell________________email___________________________
Address____

POLICY AGREEMENT

CANCELLATIONS

We require 24 hours notice for cancellations. **A missed appointment without notification is considered a broken appointment. The broken appointment fee is $50. After three broken appointments a patient may be dismissed from the practice. INTIAL__________**

UNATTENDED CHILDREN

Adults receiving treatment should not bring small children along unless another adult is present to take care of them. INTIAL__________

HIPPA

This office complies with the law regarding your privacy of information. Please initial to confirm that this office has made the written details of this law available to you. INTIAL________

PAYMENT

Fees for services are expected at time of treatment unless arrangements have been made prior to treatment. We will submitt your insurance claims and make every effort to maximize the benefits you are entitled to. We strongly encourage you to read your policy information to make sure you are getting the benefits you are paying for. If the insurance company denies your claim, you are responsible for all payment. We reserve the right to refer accounts to a collection agency. INTIAL________

CONSENT

All procedures will be explained and agreed upon prior to treatment. Your written consent is required at the time of registration.
I hearby give my consent for dental diagnosis and treatment. Routine care may consist of X-rays, restoration of decayed or broken teeth, replacement of missing teeth with prosthetic appliances, treatment of oral infections, pathological conditions, and abnormalities by chemical and/or mechanical means.