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

Medical Alert

PATIENT REGISTRATION AND MEDICAL HISTORY

Date____________________

Home # __________________ Work # ______________________ **Cell #** _______________________ **Preferred contact #** __________________

Patient____ _______ _______________________

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

Social Security # ___________________________________ E-mail Address _____________________________@___________________

Street Address ____ City_________________________ State________ Zip___________________

Sex: M F Age_________ Birthdate_________________ Single Married Widowed Separated Divorced

Employed by____ Occupation____

Business Address____ Business Phone ____________________________

Spouse Name ____ Spouse SSN# ____________________________

Spouse Employed by ____ Occupation ____

Business Address____ Business Phone ____________________________

Who is responsible for this account? ____ Relationship to Patient_____________________________

Responsible Party's SSN # ____________________ Employer _________________________________ Employer's Phone_______________________

WHOM MAY WE THANK FOR REFERRING YOU? ____

Dental Insurance Primary Carrier

Insured's Name ____

Insurance Co. ____

Ins. Co. Address ____

____

Insured's Employer ______________________________________

Insured's SSN # ____

Insured"s Birthdate ______________________________________

Group # _____________ I.D. #_____________________________

Dental Insurance Secondary Carrier

Insured's Name ____

Insurance Co. ____

Ins. Co. Address ____

____

Insured's Employer ____

Insured's SSN # ____

Insured"s Birthdate ____

Group # ________________ I.D. #____________________________________

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

Do you have any drug allergies or have you ever had an adverse reaction to any medication? **YES** **NO** If so, what? ____________________________
____

Has a physician ever told you to "pre-medicate" for dental treatment? **YES** **NO**

Have you ever had any of the following? **YES** **NO** If YES, please circle those that apply.

A.I.D.S." / HIV Disease
Allergies to Anesthetics
Allergies to Latex
Allergies to Medications/ Drugs
Allergies to Colored Dyes
Angina Pectoris
Arthritis
Back problems
Blood Disease
Cancer, Leukemia
Chemical Dependency
Chronic Diarrhea
Chronic Headaches
Circulatory Problems
Diabetes
Epilepsy/Seizures
General Allergies
Glaucoma
Heart Disease
Heart Pacemaker
Hemophilia/Excessive Bleeding
Psychiatric care
Hepatitis A
Hepatitis B
Hepatitis C
Hepatitis Type _____
Hypoglycemia
High blood pressure
Low blood pressure
Jaundice, or Liver Disease
Kidney trouble
Nervous problems
Radiation treatment
Recent Weight loss
Respiratory Disease
Rheumatic Fever
Sinus problems
Special diet
Swollen neck glands
Stroke
Thyroid Disease
Tuberculosis
Ulcer
Venereal Disease:
Type______________

- ❖ Artificial Heart Valves
- ❖ Artificial Joints
- ❖ Heart Murmur
- ❖ Mitral Valve Prolapse
- ❖ Stint
- ❖ Shunt

Physician's Name ____ Date of Last Physical _______________________

Patient Name____

Are you taking any medications (including over-the-counter) presently? YES NO If yes, please list:

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

Do you have a present or past history of abusing drugs (legal, illegal or over-the-counter)? YES NO

Are you under the care of a physician? YES NO For what conditions?____________________________

(Women) Do you suspect you are pregnant? YES NO Are you nursing? YES NO

Have you ever had a blood transfusion? YES NO

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

____

____

What is the reason for your visit today?____

Date of Last Dental Visit_________________ Last Dental Cleaning_____________ Last full Mouth X-rays_________________

What was done at your last dental visit?____

How often do you have dental examinations?_______________________________________

Previous Dentist's Name________________________________City___________________________ State_______________

How often do you brush your teeth?_____________________ How often do you floss?______________________________

What other dental aids do you use? (toothpick, electric toothbrush, etc.)____________________________

Do you have any dental problems now? YES NO If yes, please describe: ____________________________

Are any teeth sensitive to:		
Hot	Yes	No
Cold	Yes	No
Sweets	Yes	No
Biting or Chewing	Yes	No
Do you:		
Bite your lips or cheeks habitually?	Yes	No
Hold foreign objects with your teeth? (pencils, pins, nails, fingernails)	Yes	No
Tear open packages with teeth?	Yes	No
Chew ice?	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have any oral piercings?	Yes	No
Frequently get cold sores, blisters or ulcers?	Yes	No
Have you ever had:		
Oral surgery (extractions)?	Yes	No
Orthodontic treatment (braces)?	Yes	No
A serious injury to the mouth or head?	Yes	No

If yes, please describe:_________________

____

____

Have you experienced:		
Clicking or popping of the jaw with pain?	Yes	No
Difficulty in opening or closing your mouth?	Yes	No
Difficulty chewing on either side of the mouth?	Yes	No
Chronic head, neck, or shoulder aches?	Yes	No
Tired jaws, especially in the morning?	Yes	No
Clenching or grinding your teeth while awake or asleep?	Yes	No
Have you had teeth or bite adjusted due to TMJ?	Yes	No
Do you wear a night or mouth guard?	Yes	No
Have you had Periodontal (gum) treatment?	Yes	No
Notices any mouth odors or bad tastes?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Noticed any loose teeth or changes in your bite?	Yes	No
Are you interested in saving teeth that need work?	Yes	No
Smoke/ Chew Tobacco?	Yes	No
If yes, how long_________ Have you tried to quit?	Yes	No
Are you satisfied with the appearance of your teeth?	Yes	No
Interested in whitening?	Yes	No
Interested in cosmetic changes?	Yes	No

Is there anything else about having dental treatment you would like us to know (upsetting dental experiences, nervous, etc.)?

____

____

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 for 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 during the completion of this form.

Signature of: Patient / Parent / Legal Guardian____ Date__________________
(Please circle one)