

**Welcome to our Office**

|  |  |  |  |
| --- | --- | --- | --- |
| Date: |  | Medical Alert: | Yes  No |
|  |  |  |  |
| **The following information that is requested is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain with this office.**  **For privacy concerns please do not send completed personal and medical history forms via email.** | | | |

## **Registration Information**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name (Last, First): | |  | | | | |  | | |  | | | | |  | | |  | |
| Name you prefer to be called: | | | | | |  | | | |  | | | | | Occupation: | | |  | |
| Address (City, Postal Code): | |  | | | | |  | | |  | | | | |  | | |  | |
| Home Phone: |  | | | | | | Cell Phone: | | |  | | | | | Business Phone: | | | |  |
| May we call you at work? | | | | Yes No | | | | | | Email: | | | |  | | | | | |
| Date of Birth(D/M/Y): | | | / / | | | | | | | Age: | | |  | | Sex: | | Male Female | | |
| Marital Status: |  | | | | | | Name of Spouse: | | | | |  | | | | | | | |
| Preferred Appointment Time: | | | |  | | | | | Whom may we thank for referring you? | | | | | | |  | | | |
| Are other family member’s patients at our office? | | | | | Yes No | | | Names: | | |  | | | | | | | | |

## **Medical Information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Family Physician: |  | | Phone: |  |
| Medical Specialist: |  | | Phone: |  |
| In case of emergency, please contact: | |  | Phone: |  |
| Nearest relative not living with you: | |  | | |

## **Financial Information**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Person responsible for account: | | Self | | Spouse | Other | |
| **PRIMARY DENTAL INSURANCE** | | | | | | |
| Subscriber’s name: |  | | D.O.B | | |  |
| Insurance Company: |  | | Insurance year end: | | |  |
| Group Policy # |  | |  | | |  |
| Certificate or ID # |  | | Yearly max coverage: | | |  |
|  |  | |  | | |  |
| **SECONDARY DENTAL INSURANCE** | | | | | | |
| Subscriber’s name: |  | | D.O.B | | |  |
| Insurance Company: |  | | Insurance year end: | | |  |
| Group Policy # |  | |  | | |  |
| Certificate or ID # |  | | Yearly max coverage: | | |  |

## **Dental History**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Is there a dental problem you would like treated immediately? | | | | | Yes | | No | | |
| Comments: |  | | | | | |  | | |
| Date of last dental visit? | |  | | Last dental cleaning? | |  | | | |
| Last x-rays? | |  | | How often do you brush your teeth? | |  | | | |
| **Please check YES or NO to each question. If unsure of a question, please consult with dentist.** | | | | | | | | | |
|  | | | | | | | | YES | NO |
| Are you having regular dental visits? | | | | | | | |  |  |
| **Have you ever had any of the following?** | | | | | | | | | |
| Periodontal Treatment? (treatment of the gums) | | | | | | | |  |  |
| Orthodontic Treatment? (to straighten teeth) | | | | | | | |  |  |
| A bite plate or other appliance? | | | | | | | |  |  |
| Oral Surgery?(surgery in the mouth/jaw joint or implant surgery of jaw) | | | | | | | |  |  |
| Do you feel that you have bad breath? | | | | | | | |  |  |
| Do you use dental floss, proxy brush, or a Waterpik? | | | | | | | |  |  |
| How often? | | | | | | | |  | |
| Do your gums bleed when brushing or eating, or do you suffer from pain or swelling of your gums? | | | | | | | |  |  |
| Does food catch between your teeth? | | | | | | | |  |  |
| Are any of your teeth sensitive to heat, cold, sweets, or pressure? | | | | | | | |  |  |
| **Have you ever experienced any of the following jaw problems?** | | | | | | | | | |
| Popping/clicking in your jaw joints? | | | | | | | |  |  |
| Pain in your jaw joints, around your ear, or side of your face? | | | | | | | |  |  |
| Difficulty in opening or closing? | | | | | | | |  |  |
| Pain when teeth are clenched? | | | | | | | |  |  |
| Pain or difficulty when chewing? | | | | | | | |  |  |
| **Do you have any of the following habits?** | | | | | | | | | |
| Clenching or grinding your teeth while awake or asleep? | | | | | | | |  |  |
| Biting your cheeks or lips? | | | | | | | |  |  |
| Mouth breathing while awake or asleep? | | | | | | | |  |  |
| Placing foreign objects in your mouth (pencils, nails, fingernails)? | | | | | | | |  |  |
| Do you snore or have you ever been diagnosed with Obstructive Sleep Apnea? | | | | | | | |  |  |
| Do you have any emotional concerns about having dental treatment? | | |  | | | | | | |
| Are you unhappy with the appearance of your teeth? | | |  | | | | | | |
| Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or do you have any questions or concerns? | | |  | | | | | | |

## **Medical History**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Are you being treated for any medical condition at present or within the past two years? | | | | | Yes No | |
| If Yes, please explain? | |  | | | | |
| Have there been any changes in your general health in the past year? | | | | | Yes No | |
| When was your last visit to a physician? | | |  | | | |
| Last complete physical exam? | | |  | | | |
| List any PRESCRIPTION or N0N-PRESCRIPTION drugs you are taking or have recently taken (including birth control pills): | | | |  | | |
| Have you ever had any adverse or unusual reaction to any medications or injections? (e.g. penicillin, other antibiotics, aspirin, codeine, local anesthetics). Please explain: | | | |  | | |
| Have you ever been advised against taking any specific type of medication? | | | |  | | |
| **Please answer YES or NO to each question** | | | | | | |
|  | | | | | YES | NO |
| Do you have any allergies? | | | | |  |  |
| Have you ever fainted during dental or medical treatment? | | | | |  |  |
| Do you bleed excessively from a cut or injury, bruise easily, or have any blood disorders? | | | | |  |  |
| Are you on cortisone or steroid therapy? | | | | |  |  |
| Do you have any artificial joints (e.g. Hip, knee)? | | | | |  |  |
| Have you ever been advised to take antibiotics before dental treatment? | | | | |  |  |
| Do you have heart murmur, valve dysfunction (mitral valve prolapse or artificial heart valve) or have you ever had Rheumatic Fever? | | | | |  |  |
| Do you have or have had any heart or blood pressure problems (heart or stroke)? | | | | |  |  |
| Do you have, or have you ever had any chest pain, shortness of breath or any heart palpitation without exertion? | | | | |  |  |
| Are you presently suffering from any infectious diseases? | | | | |  |  |
| Do you have any condition that could affect your immune system (eg. Arthritis, AIDS, HIV infection, lupus, inflammatory bowel disease, Crohn’s disease?) | | | | |  |  |
| Please Specify: |  | | | | | |
| Have you ever had any malignant disease, or are you presently undergoing any radiation treatment/chemotherapy? | | | | |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Indicate which of the following you presently have, or ever had: (Please circle all that apply)** | | | | | | |
| Asthma | Epilepsy or Seizures | Tuberculosis | | Glandular Disorders | | |
| Bronchitis | Hepatitis | Diabetes | | Organ Transplant / Medical Implant | | |
| Emphysema | Jaundice | Kidney Disease | | Stomach/Intestinal Problems | | |
| Lung Disease | Liver Disease | Thyroid Disease | | Ulcers | | |
|  | | | | | YES | NO |
| Do you or did you smoke? | | | | |  |  |
| Do you drink alcoholic beverages on a regular basis? | | | | |  |  |
| Do you use Recreational Drugs? | | | | |  |  |
| Women Only: Are you pregnant? | | | | |  |  |
| If pregnant, delivery date? | | |  | | | |
| Are you breastfeeding? | | | | |  |  |
| Do you have a family history of Diabetes, Cancer, Heart Disease? | | | | |  |  |
| Is there anything else about your health we should be made aware of, or do you wish to speak to the dentist privately about any problem or medical condition? | | |  | | | |

## **GENERAL RELEASE**

(Please sign after completing medical history)

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. Should there be any change in either my health status or any other information I have provided, I will advise this dental office. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of this information. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature (Patient/Parent/Guardian) |  | Print Name |
|  |  |  |
| Reviewed by Treating Dentist |  | Date |