



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

OFFICE: _____

PATIENT REGISTRATION

Patient's Name: _____ Preferred Name: _____
First Middle Initial Last
Social Security #: _____ - _____ - _____ Date of Birth: _____ - _____ - _____ Sex: M F
Address: _____ Apt #: _____ City: _____
State: _____ Zip: _____
Cell Ph#: () _____ - _____ Second Ph#: () _____ - _____ Work#: () _____ - _____
Email: _____
Emergency Contact Name: _____ Relationship to patient: _____
Emergency Contact Ph#: () _____ - _____
Who can we thank for referring you? _____
Please list a friend who needs a dentist: _____
Name Phone#

ACCOUNT INFORMATION

Who is financially responsible for this account? _____
Social Security #: _____ - _____ - _____ Date of Birth: _____ - _____ - _____ DL#/State: _____
Address: _____ Apt #: _____ City: _____
State: _____ Zip: _____ Cell Ph#: () _____ - _____ Work Ph#: () _____ - _____
Home Ph#: () _____ - _____ Relationship to Patient: _____
Employed By: _____ Occupation: _____
Employer's Address: _____ Suite#: _____ City: _____
State: _____ Zip: _____

DENTAL HISTORY

- Are you having any immediate dental problems? _____ If so, please explain: _____
- When was your last visit to the Dentist? _____
- When were you teeth last cleaned? _____
- Who was you last Dentist? _____ City: _____ State: _____
- Are you satisfied with your past dentistry? Yes No
- How often do you brush your teeth? _____ Floss? _____
- Has fear or discomfort kept you from seeing a dentist on a regular basis? Yes No
- Do your gums bleed easily, feel tender or irritated? Yes No
- Are your teeth sensitive to hot, cold or sweets? Yes No
- Do your jaws feel tired? Yes No
- Do you have pain in the head, neck, shoulders or back? Yes No
- Do you have clicking or popping noises when opening or closing your mouth? Yes No
- Are you aware of grinding or clenching you teeth? Yes No
- If so, do you wear a nightguard? Yes No
- Would you like to retain health natural teeth as long as possible? Yes No

MEDICAL HISTORY

Physician's Name: _____ Office Ph#: _____ Address: _____
 _____ City: _____ State: _____ Zip: _____

Are you being treated by a physician now?	Yes	No	Identify: _____
Taking any medication?	Yes	No	Identify: _____
Allergic to any medication?	Yes	No	Identify: _____
Allergic to metals?	Yes	No	Identify: _____
Any recent serious illnesses	Yes	No	Identify: _____
Have you ever had any major surgery?	Yes	No	Identify: _____

Please CIRCLE any of the following which you have had or have at present:

Heart Trouble	Stroke	High Blood Pressure
Diabetes	Rheumatic Fever	Kidney/Liver Disorder
Eye Disorders	Tumors/Growths	Prolonged Bleeding
Tuberculosis	Asthma	Epilepsy
Hepatitis	AIDS (HIV +)	Radiation Treatment
Venereal Disease	Arthritis	Currently Pregnant
Smoking/Smokeless Tobacco	Thyroid Condition	Stomach/Intestinal Problems
Birth Control Pills	Heart Murmur	Artificial Heart Valve
Heart Pacemaker	Artificial Joints	Latex Sensitivity
Cold Sores/Fever Blisters	Fainting or Dizzy Spells	Glaucoma
Psychiatric/Psychological Care	Allergic to Anesthetic	Bruise Easily
Ulcers		

Are there any other medical problems that we should be aware of? Yes No If yes, please explain:

CONSENT FOR TREATMENT

1. I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the Doctor of any change in my health or medication.
2. I hereby consent to an examination and I authorize the Doctor to take such x-rays and perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetic, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. Lastly, I agree to be responsible for payment of all services provided on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made prior to the services being rendered.

Patient Signature: _____ Date: _____

Parent/Responsible Party Signature: _____ Date: _____

Relationship to patient: _____