REGISTRATION
AND HEALTH HISTORY

Name _____SS#_____Date of Birth _____

Address_____City, State, ZipCode _____

E-mail _____ phone: home _____cell _____ work _____

Employer _____ Insurance _____

Spouse's Name _____ Spouse's Date of Birth _____

Spouse's SS# _____ Spouse's Employer _____spouse's phone _____

How you were referred to our office _____

DENTAL HISTORY

Are you having any discomfort at this time (if yes, please explain the nature and how long) _____

_____

Date of last examination _____

Treatment you received _____

_____

Has your past dental treatment been comfortable (if not, please explain what was unpleasant) _____

_____

_____

Are you satisfied with the health and appearance of your teeth and gums _____

What would you like to change or improve if you could _____

_____

Do you want to obtain good dental health and preserve the health, appearance and comfort of your mouth through your lifetime _____

Are you interested in learning how to prevent dental disease for yourself and for members of your family _____

How often do you clean your teeth _____

Which items do you use to clean your teeth: A. toothbrush _____soft, medium, hard - B. dental floss _____

How often do you floss _____ - C. Between teeth stimulator _____ - D. water jet _____

E. electric toothbrush (brand) _____ - F. Other _____

Have you been shown how to brush and floss properly _____

Do you now have, or have you had in the past, any of the following habits: Thumb sucking _____ Nail biting _____

Chewing on pens, pencils, etc. _____ Other _____

Date of last blood pressure recorded _____ S_____/D_____

Do you smoke cigarettes, pipe, other _____Do you chew tobacco _____

Are you aware of any swelling or lump in your mouth, neck, throat or elsewhere _____

_____

Over

MEDICAL HISTORY

Name(s) of Medical Doctor(s) _____

Address(es) _____

Phone Number(s) _____

Date of last exam(s) _____Are you in good health _____

Please describe any current medical treatment or impending hospitalization _____

_____

Please list any medications or nutritional supplements you are currently taking along with dosage and frequency

_____ _____

_____ _____

_____ _____

Past hospitalizations or surgery _____Any complications _____

Do you now have, or have you had any of the following:

yes	no	heart disease	yes	no	asthma	yes	no	artificial joints/heart valve
yes	no	heart murmur or defect	yes	no	respiratory disease	yes	no	transplanted organs
yes	no	high blood pressure	yes	no	diabetes	yes	no	physical disabilities
yes	no	disease of the blood	yes	no	malignancy	yes	no	Aids/other immuno-suppressive
yes	no	excessive bleeding	yes	no	measles	yes	no	psychiatric/emotional problems
yes	no	allergies to anesthetics	yes	no	rheumatic fever	yes	no	fainting spells/seizures-epilepsy
yes	no	allergies to medicines _____	yes	no	stroke	yes	no	cardiac pacemaker
			yes	no	tuberculosis	yes	no	chemotherapy/radiation
yes	no	other allergies _____	yes	no	ulcer			
			yes	no	frequent headaches			
yes	no	kidney disease	yes	no	sinus condition			
yes	no	thyroid problems	yes	no	venereal disease			
yes	no	scarlet fever	yes	no	are you pregnant			
yes	no	burning sensation on tongue or lip	yes	no	have you ever taken fluoride supplements			

_____

_____

_____

I authorize the release of records from my current medical physician(s) and previous dentist. _____yes

Your Signature _____ **Today's Date** _____

TO BE FILLED OUT BY CLINICAL STAFF

Previous dentist _____Last Oral Exam _____
Last complete series of x-rays _____ Extractions _____ Reason _____
Replacement of missing teeth _____
Sensitivity – Hot – Cold- Pressure _____
Periodontal Treatment _____ Orthodontic Treatment _____ Endodontic Treatment _____
Gingival bleeding when brushing _____ flossing _____
Gingival swelling _____ mobility _____
TMD Evaluation – Headaches _____ Pain in and around ears _____
Sinus pain _____ Other head or neck pain _____
Popping or clicking or pain on opening _____
Previous treatment or occlusal adjustment _____

completed by _____ *date* _____