WELCOME TO OUR OFFICE

REGISTRATION INFORMATION

The information that is requested on this Questionnaire is essential to providing you with the highest standard of dental care. The protection and privacy of your personal information is important to our office and we are committed to collecting, using, and disclosing this information responsibly. ***PLEASE PRINT***

The patient is an:	ADULT ☐	CHILD☐	ADULT UNDER GUARDIANSHIP☐	Name of Guardian:	
Referred by:					

Patient Name:	(Last)	(First)	(Prefers to be called)	Birthdate:	(mm/dd/yyyy)
Contact Info:	(Home Phone)	(Business Phone)	(Cell Phone)	(Email address)	
Address:	(Street)	(Apt)	(City)		(Postal Code)

Age:		Marital Status:		Name of Spouse:		May we call you at work?	☐ Yes ☐ No
Employer:							
Person Responsible for account:				Address:			
Do you have insurance?	☐ Yes ☐ No	Insurance Company:			Policy Holder:	☐ Self ☐ Spouse	

Family Physician:	(Name)	(Address)	(Phone Number)
Are you under the care of a Medical Specialist?	☐ Yes ☐ No	(Name)	(Phone Number)
In case of emergency, please contact:	(Name)	(Relationship)	(Phone Number)

Health History

Last complete physical examination?

Indicate which of the following you presently have, or have ever had **(Please Circle)**

Asthma	Tuberculosis	Thyroid Disease	Lung Disease	Glandular Disorder	Organ Transplant/Medical Implant
Bronchitis	Diabetes	Emphysema	Kidney Disease	Ulcers	Stomach/Intestinal Problems

(Please check YES or NO to each question below)	YES	NO
1. Are you being treated for any medical condition at present or within the past year? If Yes, please explain:	☐	☐
2. Has there been any change in your general health in the past year?	☐	☐
3. Have you recently, or are you presently, taking any prescription or non-prescription drugs (including herbal remedies)? If Yes, please list:	☐	☐
4. Have you ever had any adverse or unusual reaction to any medications or injections (e.g. penicillin, or other antibiotics, aspirin, codeine, local anesthetic (dental freezing))? If yes, Please explain:	☐	☐
5. Have you ever been advised against taking any specific type of medication?	☐	☐
6. Do you have any allergies (e.g. hay fever, food allergies, latex/rubber or metal allergies)?	☐	☐
7. Do you have epilepsy or seizures?	☐	☐
8. Have you ever fainted during dental or medical treatment?	☐	☐
9. Do you bleed excessively from a cut or injury, bruise easily, or have any blood disorders? If Yes, please explain:	☐	☐
10. Are you on cortisone or steroid therapy, or, are you on a diet pill therapy?	☐	☐
11. Do you have, or have you ever had, any heart or blood pressure problem (Heart attack or stroke)? If Yes, please explain:	☐	☐

Health History continued on reverse side

Health History continued

12. Do you have, or have you ever had any chest pain, shortness of breath, or any heart palpitation without exertion?	☐	☐
13. Are you presently suffering from any infectious diseases?	☐	☐
14. Have you ever had Hepatitis, Jaundice, or any Liver Disease?	☐	☐
If Yes, please explain:		
15. Do you have any condition that could affect your immune system (e.g. Arthritis, AIDS, HIV infection, lupus, inflammatory bowel disease, Crohn's disease)? If yes, please specify:	☐	☐
16. Have you ever had any malignant disease, or are you presently undergoing any radiation treatment/chemotherapy?	☐	☐
17. Do you, or did you smoke?	☐	☐
18. Do you drink alcoholic beverages on a regular basis?	☐	☐
19. Do you use recreational drugs?	☐	☐
20. Are there any diseases or medical problems that run in your family (e.g diabetes, cancer, heart disease)?	☐	☐
21. Do you currently have, or ever had in the past, any disease, condition, or problem not listed above?	☐	☐
22. Is there anything else about your health we should be made aware of; or do you wish to speak to the doctor privately about any problem or medical condition?	☐	☐
Women Only		
23. Are you breast feeding?	☐	☐
24. Are you pregnant?	☐	☐
Expected delivery date:		
Women over 50		
25. Are you aware of your bone mineral density?	☐	☐

Notes:

Dental History

1. Is there a dental problem you would like treated immediately? ☐ Yes ☐ No Please specify:

2. Date of your last dental visit? Last dental cleaning? Last X-Rays?

3. How often do you brush your teeth? Do you feel you have bad breath? ☐ Yes ☐ No

4. Have you ever had:
   - Periodontal treatment ☐ Yes
   - Orthodontic Treatment ☐ Yes
   - A Bite Plate or any other appliance ☐ Yes
   - Bite Adjustment ☐ Yes
   - Oral Surgery (surgery in or about the mouth/jaw joint, or implant surgery) ☐ Yes

5. Do you have any emotional concerns about having dental treatment? ☐ Yes ☐ No If yes, please specify:

6. Are you unhappy with the appearance of your teeth? ☐ Yes ☐ No If yes, please specify:

GENERAL RELEASE

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. I have been advised of the privacy policy of the office and that my personal information will be collected, used, and disclosed within the guidelines of the policy. 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.

X _____ _____

(Signature) ☐Patient ☐Parent ☐Guardian (Print name of guardian)

Reviewed by treating dentist: Date: