ADULT REGISTRATION AND HEALTH HISTORY

Name _____ Single _____ Married _____ Divorced _____ Email _____

Social Security Number _____ Birthdate _____ Home Phone _____ Cell Phone _____

Residence Address _____ City _____ State _____ Zip _____

Employed By _____ City _____ State _____ Zip _____

Present Position _____ How Long Held _____ Business Phone _____

Spouse Name _____

Spouse's Social Security # _____ Spouse Birthday _____ Business Phone _____

Spouse Employed By _____City _____ State _____ Zip _____

Present Position _____ How Long Held _____

Referred By _____ Address _____

Who will pay for this account? _____

Name of your dental insurance company _____

Group # _____ Policy # _____

Name of your spouse's dental insurance company _____

Group # _____ Policy # _____

Emergency Contact: Name _____ Address_____

Cell Phone _____ Home Phone _____

Dental History

Do you have a specific dental problem? Describe _____ Yes No

Do you have dental examinations on a routine basis? Last visit _____ Yes No

Do you think you have active decay or gum disease? _____ Yes No

Do you brush and floss on a routine basis? _____ Yes No

Do your gums ever bleed? Discuss _____ Yes No

Does food catch between your teeth? _____ Yes No

Any loose teeth?_____ Yes No

Do your want to keep your remaining teeth? _____ Yes No

Do you ever have clicking, popping or discomfort in the jaw joint? _____ Yes No

Do you grind your teeth? _____ Yes No

Have your past experiences in a dental office always been positive? _____ Yes No

Do you smoke or chew? _____ Yes No

Any sores or growths in your mouth? Discuss _____ Yes No

Name of previous dentist (optional):_____ Yes No

Date of last full mouth x-rays (16 small films or panoramic): _____ Yes No

Have you or any member of your family been a patient in our office before?_____ Yes No

If so, who?_____

(over)

HEALTH HISTORY

Patient's Name | Date of Birth | Height | Weight | Date

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam_ _____
4. Are you now under a physician's care for a particular problem? ..... Y N
5. Have you ever had any serious illnesses, operations or hospitalizations? If so, describe ..... Y N

   _____

   _____

6. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? ..... Y N
   - B. Congenital Heart Disease? ..... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? ..... Y N
   - D. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing? ..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness? ..... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? ..... Y N
   - H. Kidney Disease? ..... Y N
   - I. Diabetes? ..... Y N
   - J. Thyroid Disease (Goiter)? ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach Ulcers or Colitis? ..... Y N
   - M. Glaucoma? ..... Y N
   - N. Osteoporosis? ..... Y N
   - O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
   - P. Radiation (X-ray) treatment for Cancer? ..... Y N
   - Q. Sinus or Nasal problems? ..... Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system (HIV)? ..... Y N

7. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? ..... Y N
   - B. Anticoagulants (Blood Thinners)? ..... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? ..... Y N
   - D. High Blood Pressure medications ..... Y N
   - E. Steroids (Cortisone, Prednisone, etc.)? ..... Y N
   - F. Insulin or Oral Anti-Diabetic drugs? ..... Y N
   - G. Digitalis, Inderal, Nitroglycerin or other heart drug? ..... Y N
   - I. Are you taking or ***have you ever taken*** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa)? ..... Y N
   - J. Please list any and all medications taken:

     _____

     _____

8. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novacain, etc.)? ..... Y N
   - B. Penicillin or other antibiotics? ..... Y N
   - C. Sedatives, Barbiturates? ..... Y N
   - D. Aspirin or Ibuprofen? ..... Y N
   - E. Codeine or other pain killers? ..... Y N
   - F. Latex or Rubber products? ..... Y N
   - G. Metal of any kind? ..... Y N
   - H. Other allergies or reactions? Please list ..... Y N

     _____

     _____

9. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ..... Y N
10. Have you had any serious problems associated with any previous dental treatment? ..... Y N
11. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
12. Do you wish to talk to the doctor privately about anything? ..... Y N
13. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **<u>is there any chance</u>** you might be Pregnant? ..... Y N
    - B. Are you nursing? ..... Y N

I understand the importance of a truthful and complete Health History to assist my doctor in providing the best care possible.

Date | Signature of Person Completing Health History | Doctor's Initials

<u>NOTES</u>

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