DENTAL AND MEDICAL HISTORY REGISTRATION FORM

We want to give you the best care we can, so please provide us with the most accurate record of your health to your knowledge. The little things are important, so please ask us if you have any questions or concerns with filling out this form!

Patient name: ____ Date of birth: ______________

Social security # __________________________ Male/Female Marital status: ____________

Address: ____

Phone number: ____________________________ Home _____________________________ Cell

Email address: ____

How do you prefer to be contacted? Please circle one: Home phone Cell phone Text Email

INSURANCE INFORMATION (if applicable)

Name of insured: ____Date of birth: ____________

Employer: ____

Employee ID: ____

Insurance carrier: ____

Policy number: ____

Group number: ____

Signature: ____ Date: _____________

DENTAL

How may we help you today? ____

Any pain? ◯ Yes ◯ No

Please describe: ____

How often do you brush your teeth? __________ How often do you floss your teeth? __________

How long ago was your last dental cleaning? ____

Do you wear dentures or partials? ◯ Yes ◯ No

If yes, how long have you had your current dentures/partials? ______________________________

Have you ever had a "deep cleaning" or "gum surgery"? ◯ Yes ◯ No

If yes, how long ago? ___________________

Do your gums bleed when you brush? ◯ Yes ◯ No

Are your teeth sensitive to hot or cold? Please circle: Hot Cold Neither

Are you happy with the color of your teeth? ◯ Yes ◯ No

Is there anything you would like to specifically discuss today about your smile/teeth? Please circle your interests, or describe in the line following.

Whitening Braces Veneers Change silver fillings to tooth-colored

Partials/Dentures Sealants Wisdom teeth Crowns/bridges

Night guard Sports guard Grinding/Bruxism devices Implants/Implant crowns

Implant-supported denture Sleep apnea devices Migraine/headache relief devices

Other: ____

Have you ever been told that you need to take antibiotics before any dental treatment? ◯ Yes ◯ No

If yes, for what condition? ____

The above information is given to the best of my knowledge

Signature: ____ **Date:** _____________

MEDICAL

Do you have a personal physician? ◯ Yes ◯ No

If yes, please list:

Physician's name: ____

Physician's phone number: ____

Last visit: ____

Current physical health (please circle): Good Fair Poor

Are you under the care of a physician for any condition? ◯ Yes ◯ No

If yes, please explain: ____

Do you use tobacco in any form? ◯ Yes ◯ No

If yes, for how long? ____________

Would you like assistance to stop smoking? ◯ Yes ◯ No

Do you experience frequent, heavy snoring? ◯ Yes ◯ No

Do you have significant daytime drowsiness? ◯ Yes ◯ No

Have you been told that you stop breathing while sleeping? ◯ Yes ◯ No

Do you have morning headaches? ◯ Yes ◯ No

Have you ever taken any bisphosphonates/osteoporosis medicine ? ◯ Yes ◯ No

If yes, please list: ____

Do you have any total joint replacements? ◯ Yes ◯ No

If yes, how long ago, and what area of the body? ______________________________________

Do you have any metal rods, pins, or implants in the body? ◯ Yes ◯ No

If yes, how long ago, and what area of the body? _______________________________________

Do you have any heart valve replacements? ◯ Yes ◯ No

If yes, how long ago? ____

Signature: ____ **Date:** _____________

Yes	No	Condition
◯	◯	Abnormal bleeding
◯	◯	Alcohol abuse
◯	◯	Allergies
◯	◯	Anemia
◯	◯	Angina pectoris
◯	◯	Arthritis
◯	◯	Artificial heart valve
◯	◯	Asthma
◯	◯	Blood transfusion
◯	◯	Cancer
◯	◯	Chemotherapy
◯	◯	Colitis
◯	◯	Congenital heart defect
◯	◯	Diabetes
◯	◯	Difficulty breathing
◯	◯	Drug abuse
◯	◯	Emphysema
◯	◯	Epilepsy
◯	◯	Facial surgery
◯	◯	Fainting spells
◯	◯	Fever blisters
◯	◯	Frequent headaches
◯	◯	Glaucoma
◯	◯	HIV+ or AIDS

Yes	No	Condition
◯	◯	Heart attack
◯	◯	Heart murmur
◯	◯	Heart surgery
◯	◯	Hemophilia/bleeding disorder
◯	◯	Hepatitis (Circle) A B C
◯	◯	High blood pressure
◯	◯	Joint replacement
◯	◯	Kidney problems
◯	◯	Liver disease
◯	◯	Low blood pressure
◯	◯	Mitral valve prolapse
◯	◯	Pace maker
◯	◯	Psychiatric concerns
◯	◯	Radiation therapy
◯	◯	Rheumatic fever
◯	◯	Seizures
◯	◯	Sexually transmitted disease
◯	◯	Shingles
◯	◯	Sickle cell anemia/trait
◯	◯	Sinus problems
◯	◯	Stroke
◯	◯	Thyroid problems
◯	◯	Tuberculosis
◯	◯	Ulcers

Signature: ______________________________ **Date:** ______________________________

Yes	No	Allergies
◯	◯	Aspirin
◯	◯	Codeine
◯	◯	Dental anesthetics
◯	◯	Erythromycin
◯	◯	Jewelry
◯	◯	Latex
◯	◯	Metals
◯	◯	Nickel
◯	◯	Penicillin
◯	◯	Tetracycline
◯	◯	Other ______________________

Yes	No	If female, please answer
◯	◯	Are you taking birth control pills?
◯	◯	Are you pregnant?
		How many weeks? __________
◯	◯	Are you nursing?

Have you taken any of the following osteoporosis medications? Please circle

Fosamax Boniva

Clasteon Didronel

Actonel Skelid

Please list any medications you are currently taking:

____

____

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____

Is there anything else about your medical history that you believe is important to us that we have not covered? Please list

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____

____

Signature: ______________________________

Date: ____________________________