HEALTH HISTORY & REGISTRATION

DATE _____ HOME PHONE _____

NAME _____ WORK PHONE _____
LAST FIRST INITIAL

HOME ADDRESS _____ OCCUPATION _____

TOWN _____ ZIP _____ EMPLOYER _____

AGE _____ BIRTHDATE _____ SOC. SEC. # _____

REFERRED TO US BY _____ REASON FOR THIS VISIT _____

SPOUSE'S INFORMATION: _____

NAME _____

AGE _____ DATE OF BIRTH _____ SOC. SEC. # _____

EMPLOYER NAME _____ ADDRESS _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

If you have double dental insurance coverage complete this for the second coverage.

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

*** MEDICAL HISTORY ***

	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐
For what?		
Are you currently taking any medication?	☐	☐
If yes, what?		
Have you been told by a doctor to be pre-medicated with antibiotics before Dental Treatment?	☐	☐
WOMEN Are you pregnant now?	☐	☐
Do you anticipate becoming pregnant soon?	☐	☐

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

Heart Failure
Heart Disease or Attack
Angina Pectoris
High Blood Pressure
Heart Murmur
Rheumatic Fever
Congenital Heart Lesions
Scarlet Fever
Artificial Heart Valve
Heart Pacemaker
Heart Surgery
Artificial Joint

Anemia
Stroke
Kidney Trouble
Ulcers
Emphysema
Cough
Tuberculosis (TB)
Asthma
Hay Fever
Sinus Trouble
Allergies or Hives
Diabetes

Thyroid Disease
X-Ray or Cobalt Treatment
Chemotherapy (Cancer, Leukemia)
Arthritis
Rheumatism
Cortisone Medicine
Glaucoma
Pain in Jaw Joints
AIDS
Hepatitis A (Infectious)
Hepatitis B (Serum)
Liver Disease

Yellow Jaundice
Blood Transfusion
Drug Addiction
Hemophilia
Venereal Diseases (Syphilis, Gonorrhea)
Cold Sores
Genital Herpes
Epilepsy or Seizures
Fainting or Dizzy Spells
Nervousness
Psychiatric Treatment
Sickle Cell Disease
Bruise Easily

Are you allergic or have you reacted adversely to any of the following medications?

Aspirin
Codeine
Novocaine
Xylocaine
Penicillin
Erythromycin
Tetracycline
Nitrous Oxide

Are you aware of being allergic to any other medications or substances?

If yes, please list: _____

To the best of my knowledge all the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made.

PATIENT Signature (Parent of Child) _____ Date: _____ DENTIST Signature _____