



HEALTH HISTORY & REGISTRATION

CHART ID# _____

PATIENT'S NAME: Last _____ First _____ Middle _____

ADDRESS: _____ CITY, STATE, ZIP _____

HOME PHONE: _____ WORK PHONE: _____ CELL / PAGER _____

SEX: M F BIRTH DATE ____/____/____ AGE ____ SOC. SEC.# _____

MARITAL STATUS: _____ DRIVER'S LICENSE # _____ EMAIL: _____

EMPLOYER _____ OCCUPATION _____ # OF YEARS EMPLOYED _____

INSURANCE SUBSCRIBER (IF SOMEONE OTHER THAN THE PATIENT) RELATION TO PATIENT _____

NAME: Last _____ First _____ Middle _____

ADDRESS: _____ CITY, STATE, ZIP _____

HOME PHONE: _____ WORK PHONE: _____ CELL / PAGER _____

BIRTH DATE ____/____/____ SOC. SEC.# _____ DRIVER'S LICENSE # _____

RESPONSIBLE PARTY IS ALSO PRIMARY INSURANCE POLICY HOLDER SECONDARY INSURANCE POLICY HOLDER

PRIMARY INSURANCE INFORMATION

SECONDARY INSURANCE INFORMATION

NAME OF INSURED: _____

NAME OF INSURED: _____

EMPLOYER: _____

EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

EMPLOYER'S ADDRESS: _____

INSURANCE COMPANY: _____

INSURANCE COMPANY: _____

INS. COMPANY ADDRESS: _____

INS. COMPANY ADDRESS: _____

It is important that we know about your Medical history. These facts have a direct bearing on your dental health. This information is strictly confidential and will not be released to anyone without your permission. Thank you for answering the following questions.

	YES	NO	N/A	
Are you under a physician's care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever been hospitalized or had a major operation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you taking medications, pills, or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you taking alendronate(fosamax) or risedronate(actonal) ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
For women: are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you use cigars/cigarettes, pipe, or chewing tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you use controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you allergic to any of the following?				
<input type="checkbox"/> Aspirin <input type="checkbox"/> Penicillin <input type="checkbox"/> Codeine <input type="checkbox"/> Latex <input type="checkbox"/> Metal <input type="checkbox"/> Local Anesthetics <input type="checkbox"/> Other _____				
Do you have, or had any of the following?				

	YES	NO		YES	NO
AIDS/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/Attack	<input type="checkbox"/>	<input type="checkbox"/>
Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (infectious)	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B (serum)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Lesions	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia (Bleeding Problem)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints (Hip, Knee)	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
			Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>
			Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
			Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
			Asthma	<input type="checkbox"/>	<input type="checkbox"/>
			Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
			Sinus Troubles	<input type="checkbox"/>	<input type="checkbox"/>
			Allergies or Hives	<input type="checkbox"/>	<input type="checkbox"/>
			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
			Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
			Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
			Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
			Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>
			Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>
			Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
			Cosmetic Surgery	<input type="checkbox"/>	<input type="checkbox"/>

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to the patient's health.

Signature of Patient, Parent, or Guardian _____ Date: _____ Dentist Signature _____