

HEALTH HISTORY & REGISTRATION

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ Middle Initial _____ SEX: M F BIRTHDATE _____ AGE _____
 Soc. Sec. No. _____ If Patient is a Minor, give Parent's or Guardian's Name _____ TODAY'S DATE _____
 Who May We Thank for Referring You to our Office? _____ Reason for Visit _____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle _____ MARITAL STATUS _____
 RESIDENCE Street _____ City _____ State _____ Zip _____
 MAILING ADDRESS Street _____ City _____ State _____ Zip _____
 HOW LONG AT THIS ADDRESS? _____ HOME PHONE _____ WORK PHONE _____
 PREVIOUS ADDRESS (if less than 3 yrs.) Street _____ City _____ State _____ Zip _____
 SOCIAL SECURITY NO. _____ BIRTHDATE _____ DRIVER'S LICENSE NO. _____ RELATION TO PATIENT _____
 EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

RESPONSIBLE PARTY'S SPOUSE

NAME _____
LAST FIRST MIDDLE
 EMPLOYER _____ NO. YEARS EMPLOYED _____
 OCCUPATION _____ SOC. SEC. NO. _____
 WORK PHONE _____ BIRTHDATE _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU

NAME _____
 ADDRESS _____
 CITY, STATE _____ PHONE _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____
 Insurance Co. _____
 Insurance Co. Address _____
 Insured's Employer _____
 Insured's Soc. Sec. No. _____ Group No. _____ Local No. _____

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

Insured's Name _____
 Insurance Co. _____
 Insurance Co. Address _____
 Insured's Employer _____
 Insured's Soc. Sec. No. _____ Group No. _____ Local No. _____

It is important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY

	YES	NO
HOW LONG SINCE you have seen a Dentist? _____		
Date of Last COMPLETE Dental Exam: _____		
Date of Last FULL MOUTH X-RAYS: _____ (16 small Films or Panoramic)		
Are you having PROBLEMS now? _____	<input type="checkbox"/>	<input type="checkbox"/>
WHAT? _____		
Is your present dental health POOR ?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear DENTURES? (Partials or Full)	<input type="checkbox"/>	<input type="checkbox"/>
Are you UNHAPPY with your dentures?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like to know more about PERMANENT REPLACEMENTS?	<input type="checkbox"/>	<input type="checkbox"/>
Are you APPREHENSIVE about dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any PERIODONTAL (GUM) treatments?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums BLEED , feel TENDER , or become IRRITATED ?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	<input type="checkbox"/>	<input type="checkbox"/>
Are you UNHAPPY with the APPEARANCE of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of GRINDING or CLENCHING your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have HEADACHES, EARACHES, or NECK PAINS?	<input type="checkbox"/>	<input type="checkbox"/>
Have you worn BRACES on your teeth? (ORTHODONTICS)	<input type="checkbox"/>	<input type="checkbox"/>
Do you have DISCOLORED teeth that bother you?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like your smile to LOOK BETTER or DIFFERENT ?	<input type="checkbox"/>	<input type="checkbox"/>
Do you REGULARLY use DENTAL FLOSS ?	<input type="checkbox"/>	<input type="checkbox"/>
Name of Previous Dentist: _____		
City: _____ State: _____		
How do you feel about your teeth? _____		
Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.		
FEAR of pain # _____	LACK of concern # _____	
COST of treatment # _____	MISSING work time # _____	

MEDICAL HISTORY

	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	<input type="checkbox"/>	<input type="checkbox"/>
Are you under a PHYSICIAN'S CARE now?	<input type="checkbox"/>	<input type="checkbox"/>
For What? _____		
What MEDICATIONS are you currently taking? _____		
Are you PREGNANT ?	<input type="checkbox"/>	<input type="checkbox"/>
Do you SMOKE ?	<input type="checkbox"/>	<input type="checkbox"/>
CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:		
Heart Disease or Attack	AIDS/ARC/HIV Pos.	Bruise Easily
Angina Pectoris	Hepatitis A (infectious)	Emphysema
High Blood Pressure	Hepatitis B (serum)	Tuberculosis (TB)
Heart Murmur	Liver Disease	Asthma
Rheumatic Fever	Blood Transfusion	Hay Fever
Congenital Heart Lesions	Drug Addiction	Sinus Trouble
Mitral Valve Prolapse	Hemophilia (Bleeding Problems)	Allergies or Hives
Artificial Heart Valve	Fever Blisters	Diabetes
Heart Pacemaker	Epilepsy or Seizures	Thyroid Disease
Heart Surgery	Nervousness	Radiation Treatment
Artificial Joints (Hip, Knee)	Psychiatric Treatment	Arthritis
Anemia	Glaucoma	Cortisone Medicine
Stroke	Chemotherapy (Cancer, Leukemia)	Pain in Jaw Joints
Kidney Trouble	Venereal Disease	Alcoholism
Ulcers	(Syphilis, Gonorrhea, etc.)	Cosmetic Surgery

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin	Local Anesthetic	Erythromycin
Nitrous Oxide	Codeine	Penicillin
Please list any other medications or substances you are allergic to? _____		
Please list any other Medical or Dental information you feel we should know about: _____		

FAMILY PHYSICIAN _____ PHONE NO. _____

COMPLETED TREATMENT

A B C D E					1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	F G H I J				
RIGHT																					LEFT				
T S R Q P					32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	O N M L K				

INITIAL PERIODONTAL EXAM:

- GINGIVAL INFLAMMATION: Slight Moderate Severe
- SOFT PLAQUE BUILDUP: Slight Moderate Heavy
- HARD CALC. BUILDUP: Light Moderate Heavy
- STAINS: Light Moderate Heavy
- HOME CARE EFFECTIVENESS: Good Fair Poor
- PERIODONTAL CONDITION: Good Fair Poor
- PERIODONTAL DIAGNOSIS: Normal Gingivitis
- PERIODONTITIS: Early Moderate Advanced
- MUCOGINGIVAL DEFECTS #s: _____

INITIAL X-RAY FINDINGS:

- X-RAYS TAKEN: FM-PAS BWX PANO OTHER _____
- NO BONE LOSS
- SLIGHT BONE LOSS (04600)
- MODERATE BONE LOSS (04700)
- MAJOR BONE LOSS (04800)
- BEGINNING FURCATION (04700)
- ADVANCED FURCATION (04800)
- OTHER: _____

QUADRANTS			
UR	UL	LR	LL

CLINICAL DATA:

- OCCCLUSION: Class I Class II Class III Crossbite: _____
- T.M.J. EXAM: Normal Popping Deviation Tooth Wear Pain

SHADE

Teeth	Upper	Lower
Cents		
Lats		
Cusp		
Posts		

PERIODONTAL SCREENING & RECORDING

MONTH	DAY	YEAR	

INITIAL SOFT TISSUE EXAM:

- Lips Floor of Mouth Palate Tongue Neck & Nodes

PATIENT'S TREATMENT DECISIONS:

- DOCUMENTATION OF DENTAL RECORD COMPLETED
- PATIENT INFORMED OF TX. RECOMMENDATIONS AND CONSENTS TO TX. (ALTERNATIVES DISCUSSED.)
- PATIENT WANTS NO TX. OR PARTIAL TX. INFORMED OF CONSEQUENCES AND RISKS INVOLVED.

EXISTING PROSTHESIS:

- MAX. _____ DATE PLACED: _____ CONDITION: _____
- MAND. _____ DATE PLACED: _____ CONDITION: _____

REFERRALS:

- PERIO: _____ ORTHO: _____ ENDO: _____
- ORAL SURG: _____ M.D. _____ OTHER: _____

NOTES

CONSENT

The undersigned hereby authorizes the 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 my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance.

PATIENT Signature (Parent of Child) _____

Date _____

DENTIST Signature _____

I understand that where appropriate, credit reports may be obtained.