LAST NAME _____ FIRST NAME _____ DATE OF EXAM _____

MEDICAL HEALTH HISTORY

General health
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Who is your physician?

His address

When did you have your last complete physical examination?

Are you being treated for anything now? Recent Surgery? _____

Did you ever have

☐ Kidney disease	☐ Liver Disease	☐ Aids	☐ Tuberculosis
☐ Rheumatic fever	☐ Anemia	☐ Asthma	☐ Diabetes
☐ Thyroid	☐ Hepatitis	☐ Epilepsy	☐ Heart Trouble
		☐ Venereal Disease	☐ Other _____

Is your blood pressure: ☐ high ☐ low ☐ normal

Blood pressure reading

Have you ever been treated with radiation?

Are you allergic to (Please check):
☐ Penicillin ☐ Codeine
☐ Novocaine ☐ Other

Are you taking Birth Control Pills? _____

Are you allergic to any other drugs? (Please specify)

Are you taking any medications now? If so, what? _____

	Yes	No
If female, are you pregnant? How long?		
Are you subject to prolonged bleeding?		
Are you "high strung"?		
Has your diet ever been evaluated?		
Do you have trouble sleeping?		
Do you use more than 2 pillows for sleeping?		
Do you have problems with digestion?		
Do you smoke?		
Do you snore?		

DENTAL HEALTH HISTORY

How long since your last dental examination?

What concerns you most ?

	Yes	No
Do you have any pain in your teeth because of heat, cold, sweets or when chewing?		
Does food catch between your teeth?		
Do your gums ever bleed?		
Do you clench your teeth?		
Do you ovoid any part of the mouth while brushing?		
Do your gums feel irritated, tender ar swollen?		
Are you completely happy with the appearance of your teeth?		
Do you have all your teeth (other than wisdom teeth)?		
If not, did you have missing teeth replaced?		
Were you told why your missing teeth should be replaced?		
Do you lose fillings or break silver fillings?		
Do you feel that dentures are inevitable?		
How often do you have calculus (tartar) removed? Every _____ months.		
Do you want to keep your own teeth as long as possible?		

A service charge of 1½% per Month, 18% APR, will be added to all overdue accounts. Also liable for all legal & collection fees.

SIGNATURE _____

adult registration & health history questionnaire

Please fill in your answers as thoroughly as possible. In our office we are interested in developing a complete dental health program for you. In order to do this we must know as much about the individual as we do about your teeth. No two people are the same; no two mouths are alike. All information, of course, will be held in strict confidence.

DATE _____

PATIENT'S NAME _____ DATE OF BIRTH _____

NAME (HUSBAND OR WIFE) _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WHAT IS YOUR OCCUPATION? _____

CELL PHONE _____

ARE YOU ASSOCIATED WITH A DENTAL INSURANCE PLAN? _____ NAME OF INSURANCE COMPANY _____

_____ UNION (LOCAL#) _____ POLICY # _____

NAME AND ADDRESS OF PERSON RESPONSIBLE FOR PAYMENT _____

_____

FOR WHAT COMPANY DO YOU WORK? _____

BUSINESS PHONE _____ EXT _____

IF MARRIED, OCCUPATION OF YOUR HUSBAND (OR WIFE) _____

FOR WHAT COMPANY DOES HE (SHE) WORK? _____

PHONE _____ EXT _____

NUMBER OF CHILDREN IN FAMILY? _____ AGES _____

SOCIAL SECURITY NO. _____ E-MAIL ADDRESS _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

ADDRESS _____

THANK YOU