Name: Date:

Medical History

		Yes	No	Comments (D.D.S.)
1	Rheumatic Fever			
2	Heart Murmur			
3	Abnormal Heart Condition			
4	Heart Attack			Year:
5	Pacemaker			
6	Artificial Joints			
7	High Blood Pressure			BP Today /
8	Blood Disorder			
9	Healing Complications			
10	Epilepsy/Seizures			
11	Diabetes			
12	Hepatitis			Year: Type:
13	Contact with AIDS			
14	Kidney Disease			
15	Resp. Disease/TB/ Asthma/Hay Fever			
16	Arthritis			
17	Ulcers			
18	Canker Sores/Cold Sores			
19	Chemically Dependent			
20	Taking Drugs or Medications?			
21	Do You Smoke?			
22	Presently Under Care of M.D.			Physician's Name:
23	Do you have any current medical problems?			
24	Allergies to Drugs or Medications?			
25	Women: Pregnant Now?			
26	Blood Transfusion?			
27	Had a Complete Physical?			Year:

Dental History

1. Reason for this visit? ______
2. Date/year last treated? ______
3. Last Dentist visited? ______
4. How often do you brush?______ floss?______
5. Do you clench or grind your teeth?______
6. Any sensitive teeth? Hot, cold, sweets or chewing?______ Where?______
7. Does food catch between your teeth?______
8. Do your gums bleed?______ Where?______
9. Any loose teeth?______ Where?______
10. Do you prefer an anesthetic for dental treatment? ______
11. Do you prefer nitrous oxide for dental treatment? ______
12. Are you satisfied with your previous dentistry? ______
13. Additional comments: ______

Children Only:

1. Is this your child's first dental visit?
   ☐ Yes ☐ No
   If "No" give approximate date of last dental visit? ______
2. Do you have city water? ☐ Yes ☐ No ☐ Don't Know

Patient/Guardian Signature

Date	Medical History Change	Pt. Initial	BP	Date	Medical History Change	Pt. Initial	BP

HEALTH EVALUATION

REGISTRATION FORM

DATE ____________________

PATIENT INFORMATION:

NAME ____________________ (first) ____________________ (middle) ____________________ (last)

ADDRESS ____________________ CITY ____________________ ST __________ ZIP __________

HOME PHONE ____________________ EMPLOYER ____________________ WORK PHONE ____________________

BIRTHDATE ____________________ MALE __________ FEMALE __________ MARRIED __________ SINGLE __________

STUDENT ____________________ NAME OF COLLEGE ____________________

SPOUSE INFORMATION:

NAME ____________________

EMPLOYER ____________________ BUS. PHONE ____________________

ACCOUNT INFORMATION:

PERSON RESPONSIBLE FOR ACCOUNT:

NAME ____________________ ADDRESS ____________________ PHONE ____________________

DRIVER'S LICENSE # ____________________ SS # ____________________

EMPLOYER ____________________ BUS. PHONE ____________________

BUSINESS ADDRESS ____________________

PRIMARY DENTAL INSURANCE:

PRIMARY DENTAL INSURANCE COMPANY ____________________

POLICY HOLDER ____________________ BIRTHDATE ____________________

EMPLOYER ____________________ ADDRESS ____________________

GROUP # ____________________ POLICY I.D. OR SS # ____________________

PLEASE LIST OTHER FAMILY MEMBERS COVERED BY THIS INSURANCE

FULL NAME(S) ____________________

SECONDARY DENTAL INSURANCE:

INSURANCE COMPANY ____________________

POLICY HOLDER ____________________ BIRTHDATE ____________________

EMPLOYER ____________________ ADDRESS ____________________

GROUP # ____________________ POLICY I.D. OR SS # ____________________

PLEASE LIST OTHER FAMILY MEMBERS COVERED BY THIS INSURANCE

FULL NAME(S) ____________________

ARE YOU COVERED UNDER MEDICAL ASSISTANCE? ____________________

MA # ____________________ BIRTHDATE ____________________

ADDITIONAL INFORMATION:

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ____________________

DATE OF LAST DENTAL VISIT ____________________

IS ANOTHER MEMBER OF YOUR FAMILY A PATIENT AT OUR OFFICE? ____________________

FULL NAME(S) ____________________

NAME OF NEAREST RELATIVE (not living with you) ____________________

ADDRESS ____________________ PHONE NUMBER ____________________