CONFIDENTIAL REGISTRATION/HEALTH HISTORY

Name Single Married

Social Security number | Birth Date | Email Address

Address | City | State | Zip

Home Phone | Work Phone | Cell Phone

Employer | City | Driver License No.

Spouse/Partner's Name | Birth Date | Work/Cell Phone

Dental Insurance | Group # | Policyholder

Dental Insurance (2ndary) | Group # | Policyholder

Whom may we thank for referring you?

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes No Is your general health good?
   If NO, explain _____
2. Yes No Has there been a change in your health within the last year?
   If YES, explain _____
3. Yes No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain _____
4. Yes No Are you being treated by a physician now? If YES, explain _____
   Date of last medical exam? _____ Reason for exam _____
5. Yes No Have you had problems with prior dental treatment?
   If YES, explain _____
   Date of last dental exam _____ Name of last treating dentist _____
6. Yes No Are you in pain now?
   If YES, explain _____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please Circle)

Chest Pain (angina)	Blood in stools	Frequent vomiting
Fainting Spells	Diarrhea or constipation	Jaundice
Recent significant weight loss	Frequent urination	Dry mouth
Fever	Difficulty urinating	Excessive thirst
Night sweats	Ringing in ears	Difficulty swallowing
Persistent cough	Headaches	Swollen ankles
Coughing up blood	Dizziness	Joint Pain or stiffness
Bleeding Problems	Blurred vision	Shortness of breath
Blood in urine	Bruise easily	Sinus Problems

III. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle)

Aspirin	Valium	Tetracycline
Darvon	Demerol	Vicodin
Codeine	Penicillin	Percodan
Local anesthetic (Novacaine or Xylocaine)	Latex	Food
Nitrous oxide	Erythromycin	Metal

Others: _____

IV. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please Circle)

Heart disease	AIDS/HIV	Psychiatric care
Family history of heart disease	Surgeries	Osteoporosis
Heart attack	Hospitalization	Thyroid disease
Artificial joint	Diabetes	Asthma
Stomach problems or ulcers	Family history of diabetes	Hepatitis
Heart defects/Pacemaker	Tumors or cancer	Sexual transmitted disease
Heart murmurs	Chemotherapy	Herpes
Rheumatic fever	Radiation	Canker or cold sores
Skin disease	Arthritis, rheumatism	Anemia
Hardening of arteries	Emphysema or other lung disease	Liver disease
High blood pressure	Kidney or bladder disease	Eye disease
Seizures	Stroke	Transplants
Cosmetic Surgery	Eating disorders	Tuberculosis

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS:

Recreation drugs	Tobacco in any form	Antibiotics
Over-the-counter medicines	Alcohol	Supplements
Weight loss medications	Bisphosphonate (Fosamax)	Aspirin
Coumadin		

Please list: _____

VI. WOMEN ONLY

Yes No Are you or could you be pregnant?
If YES, what month? _____
Yes No Are you nursing?
Yes No Are you taking birth control pills?

VII. ALL PATIENTS

Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____
_____
Yes No Have you ever been pre-medicated for dental treatment? If YES, why _____
Yes No Have you ever taken Fen-Phen? If YES, when _____

Yes No Is there any issue or condition that you would like to discuss with the dentist in private?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone number: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my heath and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian) **Date** **Signature of Dentist** **Date**

MEDICAL UPDATES
I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATEINT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIAL
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____