

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

CHILD REGISTRATION

DATE			
NAME			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
BIRTH DATE	AGE	MALE	FEMALE
SCHOOL		GRADE	
SOCIAL SECURITY NO.			

DENTAL INSURANCE	
PRIMARY CARRIER	
INSURANCE	
GROUP NO.	
ID NUMBER	
DATE OF BIRTH	DATE EMPLOYED
EMPLOYER	
EMPLOYEE SOCIAL SECURITY NO.	
SECONDARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
ID NUMBER	
DATE OF BIRTH	DATE EMPLOYED
EMPLOYER	
EMPLOYEE SOCIAL SECURITY NO.	

ACCOUNT INFORMATION	
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT	
NAME	
RELATIONSHIP TO PATIENT	
ADDRESS	
CITY STATE ZIP	
PHONE NO.	
MOM	
NAME	
EMPLOYER	
BUSINESS PHONE NO.	EXT.
CELL	
EMAIL	
DRIVERS LICENSE #	
DAD	
NAME	
EMPLOYER	
BUSINESS PHONE NO.	EXT.
CELL	
EMAIL	
DRIVERS LICENSE #	

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?	
NAME:	RELATIONSHIP:
REFERRED TO US BY	
PERSON TO CONTACT FOR EMERGENCY	
PHONE NUMBER	
ADDRESS	
CITY	STATE ZIP

Please turn over and sign

Patient Name _____

DENTAL HISTORY

Patient Account No. _____

Medical Alert _____

*Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form.
All information is completely confidential.*

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or other oral lesions?	Yes	No

Do your gums bleed or hurt?

Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breath while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause _____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No

Do you feel nervous about having dental treatment?	Yes	No
If so, what is your biggest concern?	_____	

Have you ever had an upsetting dental experience?	Yes	No
If yes, please describe	_____	

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

(Please complete other side)

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If Yes, for what? _____

Physician's Name _____ Phone # _____

Have you been hospitalized or had a major operation in past five years? Yes No If Yes, why? _____

Do you take any blood thinners or low dose aspirin? Yes No If Yes, how often? _____

Are you taking any medications, pills, or drugs? Yes No If Yes, please list prescribed/over the counter meds: _____

Have you ever taken or are you taking any bone-density medication (Fosamax, Boniva, Actonel or Any Other)? Yes No

Have you received a diagnosis for Obstructive Sleep Apnea? Yes No Do you use a CPAP machine? Yes No

Are you allergic to any of the following? (Circle)

Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Drugs
Local Anesthetics Other: _____

Do you have, or have you had, any of the following?

Table with 8 columns of medical conditions and Yes/No response options. Conditions include AIDS/HIV Positive, Alzheimer's, Cancer, Anemia, Yellow Jaundice, Arthritis/Gout, Artificial Heart Valve, Artificial Joint, Asthma, Blood Disease, Blood Transfusion, Dementia, Chemotherapy, Chest Pains, Chronic Cough, Cold Sores, Cortisone Medicine, Diabetes, Diet (Special/Restricted), Easily Winded, Emphysema, Epilepsy or Seizures, Excessive Bleeding, Bruise Easily, Fainting/Dizziness, Fever Blisters, Glaucoma, Hay Fever, Heart Attack/Failure, Heart Murmur, Heart Pacemaker, Heart Trouble/Disease, Hemophilia, Hepatitis A, Hepatitis B or C, Herpes, High Blood Pressure, High Cholesterol, Allergies or Hives, Hypoglycemia, Irregular Heartbeat, Kidney Problems, Leukemia, Liver Disease, Low Blood Pressure, Lung Disease, Mitral Valve Prolapse, Osteoporosis, Radiation Treatment, Recent Weight Loss/Gain, Renal Dialysis, Rheumatic Fever, Rheumatism, Scarlet Fever, Shingles, Sickle Cell Disease, Sinus Trouble, Psychiatric Care, Stroke, Swelling of Limbs, Thyroid Disease, Tuberculosis, Tumors or Growths, Ulcers.

Do you have or have you had any disease, condition, or problem not listed? Yes No If Yes, please list: _____

Women are you: Pregnant? Yes No If Yes, How many months? _____ Nursing? Yes No Taking birth control? Yes No

To the best of my acknowledgement, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes.

Parent/Guardian Signature _____ Date _____