Registration / Health History Form

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your heath. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Patient Name: _____ □ Single □ Married □ Widowed □ Divorced □ Child

Date of Birth _____ Social Security #_____

Address: _____City _____ State _____ Zip Code_____

Home Phone (_____) _____ Cell (_____) _____

E-Mail _____ Employer_____

Work Phone (_____) _____ Ext: _____ Present Position_____

Pharmacy Name _____ Pharmacy Phone (_____) _____

How should we contact you? ..... □ Home Phone □ Cell Phone □ E-mail □ Text

Best time to contact you? …….. □ Morning □ Afternoon □ Evening □ Other: _____

Emergency Contact _____ Relationship to Patient_____ Phone (_____) _____
Full Name

Whom may we thank for referring you? _____

E-Mail Consent: I agree that the dental practice may communicate with me electronically at the e-mail listed above. I am aware that there is some level of risk that third parties might be able to read unencrypted e-mails.

X _____ **X** _____
Signature of Patient (Parent or Legal Guardian) **Date**

Financial Responsibility and Dental Insurance Information

Person Responsible for Payment: _____ Relationship to Patient_____

Primary Dental Insurance Information

Name of Insured
_____

Patient's relationship to insured:
□ Self □ Spouse □ Child □ Other_____

Insured's Date of Birth
_____

Insured's Social Security #
_____

Insured's Address (if different than patient's)
_____

Insured's Employer Name
_____

Name of Insurance _____

ID # _____ Group #_____

Phone
Number_____

Secondary Dental Insurance Information

Name of Insured
_____

Patient's relationship to insured:
□ Self □ Spouse □ Child □ Other_____

Insured's Date of Birth
_____

Insured's Social Security #
_____

Insured's Address (if different than patient's)
_____

Insured's Employer Name
_____

Name of Insurance _____

ID # _____ Group #_____

Phone
Number_____

This signature on file is my authorization for the release of information necessary to process my insurance claim. I hereby authorize payment of dental benefits otherwise payable to me, directly to Dr. Jay Freedman.

X_____ **X** _____
Signature of Insured **Date**

What is the reason for your dental visit today?
_____

How do you feel about your smile?
_____

Dental Information:

For the following questions, please mark (X) for your responses to the following questions.

	Yes	No
Do your gums bleed when you brush or floss? ……	□	□
Does food or floss catch between your teeth? ……	□	□
Is your mouth dry? ……	□	□
Are you currently experiencing any dental pain or discomfort? ……	□	□
Do you have earaches or neck pains? ……	□	□
Do you brux or grind your teeth? ……	□	□

	Yes	No
Do you have any clicking, popping or discomfort in the jaw? ……	□	□
Do you have sores or ulcers in your mouth? ……	□	□
Do you participate in active recreational activities?	□	□
Have you ever had a serious injury to your head or mouth? ……	□	□
Are your teeth sensitive to cold, hot, sweets or pressure? ….	□	□

Other:

_____

Medical Information:

Please mark (X) for your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No
Are you now under the care of a physician?	☐	☐

Physician Name: Phone: ( )

_____

Are you in good health?	☐	☐
Has there been any change in your health within the past year?.....	☐	☐

If yes, what condition is being treated?

_____

Date of last physical exam:

_____

Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐

If yes, what was the illness or problem?

_____

	Yes	No
Joint Replacement Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐

Date: _____

Do you use tobacco (smoke, snuff, chew or vape)?	☐	☐

-If so, how interested are you in stopping? (Circle one)

VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages (more than 2 per day)?	☐	☐
Do you use recreational drugs (i.e. Marijuana, Cocaine, I.V. Drug Use, etc.)?.....	☐	☐

WOMEN ONLY—Are You:

Pregnant? ……....	☐	☐

Due Date: _____

Taking birth control or hormonal replacement? ……..…..	☐	☐
Nursing? ……..…..….....	☐	☐

Are you taking or have you recently taken any prescription or over the counter medicine(s) Yes □ No □

Do you take the following?

Blood Thinner - Name: _____

Immunotherapy Drug - Name: _____

Steroid Therapy - Name: _____

Rescue Inhaler - Name: _____

Are you taking or have taken in the past or are you scheduled to begin taking any of the medications:

Alendronate (Fosamax®) or Risedronate (Actonel®) or Osteoporosis medications?

YES □ NO □ If yes what method was it taken? (circle one) IV / ORAL

Please list all medications, including vitamins, natural and/or herbal diet supplements:

Name:	Dosage:	Reason:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please use back of page for additional medications or provide a printed/written list.

Allergies - Are you allergic to or have you had a reaction to any of the following - To all **YES** responses, **specify type of reaction.**

	Yes	No	Reaction
Local anesthetics……	□	□	_____
-Specify: _____			
Aspirin……	□	□	_____
Antibiotics……	□	□	_____
-Specify: _____			
Sulfa drugs……	□	□	_____
Narcotics……	□	□	_____
-Specify: _____			
Barbiturates, Sedative or Sleeping pills……	□	□	_____
-Specify:_____			

	Yes	No	Reaction
Nuts……	□	□	_____
-Specify:_____			
Food ……	□	□	_____
-Specify: _____			
Metals……	□	□	_____
-Specify: _____			
Iodine……	□	□	_____
Animals……	□	□	_____
-Specify: _____			
Hay fever/seasonal Allergies….	□	□	
Other: _____			

Please mark (X) for your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No
Cardiovascular Disease……	□	□
AFib / Tachycardia……	□	□
Angina……	□	□
Tuberculosis……	□	□
If yes when: _____		
Arteriosclerosis……	□	□
Congestive Heart Failure ……	□	□
Damaged Heart Valves……	□	□
Heart Attack……	□	□
Heart Surgery……	□	□
Stroke……	□	□
Pacemaker……	□	□
Chest pain upon exertion……	□	□
Rheumatic Fever ……	□	□
Heart Murmur……	□	□
Congenital Heart Disease……	□	□
Congenital Heart Failure……	□	□
Mitral Valve Prolapsed……	□	□
Low blood pressure……	□	□
High blood pressure……	□	□
Abnormal Bleeding……	□	□
Anemia……	□	□
Blood Transfusion……	□	□
If yes when: _____		
Hemophilia……	□	□
Arthritis……	□	□
Rheumatoid Arthritis……	□	□
Autoimmune Disorder……	□	□
--Specify: _____		
Systemic Lupus Erythematosus……	□	□
Asthma……	□	□
Bronchitis……	□	□
Emphysema/ COPD……	□	□
Sinus Problems……	□	□
AIDS or HIV Infection……	□	□
Sexually transmitted disease……	□	□

	Yes	No
Cancer……	□	□
Type: _____		
Year: _____		
Chemotherapy ……	□	□
Head or Neck Radiation Treatment …..	□	□
Chronic Pain……	□	□
--Specify: _____		
Diabetes (circle type) Type I or Type II	□	□
Eating Disorder……	□	□
Malnutrition……	□	□
Weight Loss - Severe or Rapid ……	□	□
Gastrointestinal Disease……	□	□
--Specify: _____		
G.E. Reflux / Persistent Heartburn……	□	□
Ulcers……	□	□
Thyroid Condition……	□	□
Glaucoma……	□	□
Hearing Problems……	□	□
Migraines / Severe Headaches ……	□	□
Epilepsy……	□	□
Seizures……	□	□
Neurological Disorder……	□	□
--Specify: _____		
Anxiety / Depression……	□	□
Mental Health Disorders……	□	□
--Specify: _____		
Sleep Disorder……	□	□
Recurrent Infections……	□	□
--Specify: _____		
Kidney Disease……	□	□
Jaundice ……	□	□
Liver Disease……	□	□
Hepatitis (circle type) A B C……	□	□
Excessive Urination……	□	□
Night Sweats……	□	□
Osteoporosis……	□	□
Persistent Swollen Glands in Neck……	□	□

Other(s):_____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any actions they take or do not take because of errors or omissions that I may have made in the completion of this form. I understand this document will be scanned and that a printout will be considered the original document.

X _____ **X** _____

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