Date:__________________

WELCOME TO OUR OFFICE
Registration Information

MEDICAL ALERT	

The information that is requested on this Questionnaire is essential to providing you with the highest standard of dental care. The protection and privacy of your personal information is important to our office and we are committed to collecting, using and disclosing this information responsibly. **PLEASE PRINT.**

This patient is an: ADULT ☐ CHILD ☐ ADULT UNDER GUARDIANSHIP ☐

Name of Guardian:_________________________________ Referred by:____

Name: (Last) (First) (Initial)	(Prefers to be called)
Address: (Street) (Apt. #) (City) (Postal Code)	

Birth Date: M.___ D. ___ Y.____

Bus. Phone: ( ) ____-______

Home Phone: ( ) ___-_____

Cell Phone: ( ) ____-______

Age ____ Sex ____ Marital Status _____ May we call you at work? Yes ☐ No ☐ Employer:___________________________________

Person responsibile for account: ____________________ Name of Spouse:____

Do you have insurance? Yes ☐ No ☐ Insurance Co.________________________________ Policy No. ________________________

Family Physician: (Name) (Address)	Phone: ( )	
Are you under the care of a Medical Specialist? Yes ☐ No ☐ ________________________	Phone: ( )	
In case of an emergency, please contact: ____	Phone: ( )	

DENTAL HISTORY (Please ✓ Yes or No to each Question. If unsure of a question, please consult with the dentist.)

	YES	NO
Is there a dental problem you would like treated immediately? Yes No Date of last dental cleaning: ________ visit: _________ X-rays: _______	☐	☐
1. Have you been seeing a dentist regularly?	☐	☐
2. Have you ever had periodontal treatment or orthodontic treatment?	☐	☐
3. Have you ever had a bite plate or any other appliance?	☐	☐
4. Oral surgery? (surgery in or about the mouth/jaw joint, or implant surgery in one or both of your jaw joints?)	☐	☐
If you answered “yes” to the last question, who performed the surgery? When was it done?	☐	☐
5. Are there any growths or sore spots in your mouth?	☐	☐
6. Do your gums bleed when brushing or eating, or, do you suffer from pain or swelling of your gums?	☐	☐
7. Have you noticed any loose teeth, or, have any of your teeth shifted?	☐	☐
8. Does food catch between your teeth?	☐	☐
9. Are any of your teeth sensitive to sweets, cold, heat or pressure?	☐	☐
10. Have you been advised to take antibiotics before a dental appointment?	☐	☐
11. Do you use your dental floss, proxabrush or stimudents? How often?	☐	☐
12. How often do you brush your teeth? Do you feel that you have bad breath?	☐	☐
13. Have you ever experienced any of following jaw problems: pain, popping or clicking when opening, closing or chewing?	☐	☐
14. Do you have any of the following habits: clenching, grinding, cheek biting, mouth breathing. biting foreign objects (nails and pens)?	☐	☐
15. Do you have any emotional concerns about having dental treatment?	☐	☐
16. Are you dissatisfied with the appearance of your teeth? Or, what would you like to see changed?____	☐	☐
17. Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or, do you have any questions or concerns?____	☐	☐

(Complete both sides before signing)

General Release

I, the undersigned, certify that I have provided an accurate and complete personal and medical - dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical - dental history. **Should there be any change in either my health status or any other information I have provided, I will advise this dental office.** I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

X____ ________________________________

PATIENT ☐ PARENT ☐ GUARDIAN ☐ (Print Name of Guardian)

HEALTH HISTORY (Please ✓ Yes or No to each Question. If unsure of a question, please consult with the dentist.)

Question	YES	NO
1. Are you being treated for any medical condition at present or within the past two years? If yes, please explain: ______________________________ ______________________________ Physician: ______________________________ Phone: ______________________________	☐	☐
2. Have you been hospitalized in the past two years?	☐	☐
3. When was your last visit to a Physician? ______________________________ Last complete physical examination? ______________________________	☐	☐
4. Have you recently, or are you presently, taking any prescription or non-prescription drugs incl. herbal remedies?	☐	☐
5. Are you allergic to any medications?	☐	☐
6. Do you have any other allergies?	☐	☐
7. If yes, what is your reaction to your allergies, if any? ______________________________		
8. Is there a family history of Diabetes, Cancer or Heart Disease?	☐	☐
9. Do you bleed EXCESSIVELY from a cut or injury, or bruise easily?	☐	☐
10. Do your ankles, feet or hands swell?	☐	☐
11. Has your weight, appetite or energy level changed dramatically recently?	☐	☐
12. Do you follow a special diet or are you on a diet pill therapy?	☐	☐
13. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs?	☐	☐
14. Do you have FREQUENT SEVERE headaches, earaches, ear/throat infections?	☐	☐
15. Have you ever had any injury or surgery to your face or jaws?	☐	☐
16. Do you wear eyeglasses or contact lenses?	☐	☐
17. Do you have any hearing difficulties?	☐	☐
18. Do you smoke or use any other forms of tobacco?	☐	☐
19. Are you alcohol and/or drug dependent?	☐	☐
20. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:	☐	☐

	YES	NO		YES	NO		YES	NO
HIV/A.I.D.S	☐	☐	Glaucoma	☐	☐	Lupus	☐	☐
Anemia	☐	☐	Head/neck injuries	☐	☐	Malignant Hyperthermia	☐	☐
Angina Pectoris	☐	☐	Heart disease or attack	☐	☐	Mental/nervous disorder	☐	☐
Arthritis/rheumatism	☐	☐	Heart murmur	☐	☐	Mitral valve prolapse	☐	☐
Artificial heart valve	☐	☐	Heart pacemaker	☐	☐	Organ transplant/medical implant	☐	☐
Artificial joints (hip, knee)	☐	☐	Heart rhythm disorder	☐	☐	Psychiatric treatment	☐	☐
Blood disorders	☐	☐	Heart surgery	☐	☐	Radiation treatment/chemotherapy	☐	☐
Bronchitis	☐	☐	Hepatitis A B C ____________	☐	☐	Scarlet fever -> Rheumatic fever	☐	☐
Cancer	☐	☐	Herpes	☐	☐	Sickle cell disease	☐	☐
Circulation problems	☐	☐	High/Low blood pressure	☐	☐	Sinus trouble	☐	☐
Congenial heart lesions	☐	☐	Hodgkins disease	☐	☐	Stomach/intestinal problems/Ulcers	☐	☐
Cortisone/steroid	☐	☐	Hyper (Hypo) Glycemia	☐	☐	Stroke	☐	☐
Crohn's disease	☐	☐	Hypertension	☐	☐	Thyroid disease	☐	☐
Diabetes	☐	☐	Inflammatory bowel disease	☐	☐	Tuberculosis	☐	☐
Emphysema	☐	☐	Jaundice	☐	☐	Venereal Disease	☐	☐
Epilepsy or seizures	☐	☐	Kidney disease	☐	☐	Are you on blood thinners?	☐	☐
Fainting or dizzy spells	☐	☐	Liver disease	☐	☐	Are you taking bone strengtheners?	☐	☐
Grandular disorders	☐	☐	Lung disease	☐	☐	Other ____________		
21. Has the CHILD PATIENT recently had any of the following (indicate approximate date.)			Measles ____________	☐	☐	Strep throat ____________	☐	☐
			Mumps ____________	☐	☐	Tonsillitis ____________	☐	☐
			Chicken Pox ____________	☐	☐			

Question	YES	NO
22. Do you currently have, or have you had in the past, any disease, condition or problem not listed above?	☐	☐
23. Is there anything else about your health we should be made aware of?	☐	☐
24. Do you wish to speak privately to the Doctor about any problem or medical condition?	☐	☐

25. **WOMEN ONLY:** Are you pregnant or suspect you may be? ________ Expected delivery date? ____________ Are you breast feeding? ________
Are you taking any birth control pills? ____________

NOTE: IT IS IMPORTANT THAT ANY CHANGE IN YOUR HEALTH STATUS BE REPORTED TO OUR OFFICE.

Reviewed by Treating Dentist: ______________________________ Date: ____________________