DENTAL REGISTRATION AND HEALTH HISTORY

Date_____

Patients Name_____ Preferred Name?_____

Sex: M F Age:_____ Birth Date:_____/_____/_____ SS#_____-_____-_____

Mailing Address_____ City_____ State_____ Zip

Home #:_____ Cell#:_____ Work#: _____

Employer:_____ Email Address: _____

If the person responsible for this patients account is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section titled "Insurance Information"

Name of responsible party_____ Relationship to Patient_____

Mailing Address_____ City_____ State_____ Zip

Sex: M F Age:_____ Birth Date:_____/_____/_____ SS# _____ - _____ - _____

Home #:_____ Cell#:_____ Work#:_____

Email Address:_____ Employer:_____

INSURANCE INFORMATION

Policy Holders Name_____ Relationship to Patient_____

Policy #_____ Date of Birth _____/_____/_____

Name of Employer_____ Employer Address_____

Insurance Co._____ Phone #_(_____)_____-_____ Group #_____

SECONDARY INSURANCE INFORMATION

Policy Holders Name_____ Relationship to Patient_____

Policy #_____ Date of Birth_____/_____/_____

Name of Employer_____ Employer Address_____

Insurance Co._____ Phone #_(_____)_____-_____ Group #_____

Answers to the following questions are for our records only and will be considered confidential.

1. Have you or any member of your family been seen by us before? YES NO
   If yes, Which family member (s)?_____
2. Date of last physical examination_____ Physician's name_____
3. Date of last dental examination _____ Date of last dental x-rays_____
4. Previous Dentist's Name _____ City/ State_____
5. Are you having pain or discomfort at this time? YES NO
6. Do you feel nervous about having dental treatment? YES NO
7. Have you ever had a bad experience in a dental office? YES NO
8. Is there anything you dislike about your smile? YES NO
9. Is there anything you would like to speak with the doctor about in private? YES NO
10. Have you been a patient in the hospital during the past two years? YES NO
11. Have you been under the care of a medical doctor during the past two years? YES NO
12. Have you taken any medications or drugs in the past two years? YES NO
13. Are you taking any vitamins, herbal supplements or "cures"? YES NO
14. Have you ever had excessive bleeding requiring special treatment? YES NO