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 health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Registration and Health History Form

Today's Date:___________

Name Last	First	Middle	Email
Address	City	State	Zip
Home Phone (Please √ preferred number) ☐	Cell Phone ☐	Work Phone ☐	
SS# / State ID	Occupation	Date of Birth	Sex
Emergency Contact	Relationship	Home Phone	Cell Phone

Dental Information

Please mark (X) your responses to the following questions. Check **?** if you do not know the answer.

	Y	N	?
Are you currently experiencing dental pain or discomfort?			
Are your teeth sensitive to cold, hot, sweets, or pressure?			
Have you had any periodontal (gum) treatments?			
Have you ever had orthodontic treatment?			
Is your home on well water?			
Have you had any problems associated with previous dental treatment?			
Have you ever had a serious injury or surgery to your head or mouth?			

TMJ (Jaw Joint)	Y	N	?
Do you have frequent headaches or neck pains?			
Do you clench or grind your teeth?			
Do you have any clicking, popping or discomfort in the jaw?			
Do you wear, or have you ever worn, a nighttime bitesplint or mouth guard?			
Do you wear dentures or partial dentures?			

Were dental x-rays taken in the last 365 days?:

Date of your last dental appointment:
What was done at that time?

How did you hear about our office?

How do you feel about your oral health and appearance (is there anything you would like to change)?

What is the reason for your dental visit today?

Medical Information

	Y	N	?
Do you have a general physician?			

Physician Name:	Phone
Address	

	Y	N	?
Have you had a serious illness, operation or been hospitalized in the past 10 years?............			

If yes, what was the illness or problem?

Date of Last Physical Exam?

Please list all the prescription/OTC/ diet supplements you are taking **AND** the reason you are taking them.

1.
2.
3.
4.
5.
6.

Medical Information

	Y	N	?		Y	N	?
Do you use tobacco / nicotine (smoke, chew, E-cigarettes)? How Long? ____ How much? ____				Were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia~ or Zometa''') for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?..........			
If so, are you interested in quitting?							
Do you use marijuana or recreational drugs							
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?............................							
History of **orthopedic joint replacement**? Which joint? ____ Date: ____. Have you had any complications?				Have you taken an oral bisphosphonate for osteoporosis or osteopenia like, Fosamax, Boniva, Actonel, Zometa, Reclast?			

Allergies – Are you allergic to or have you had a reaction to:

	Y	N	?		Y	N	?
Penicillin				Sulfa Drugs			
Erythromycin				Codeine			
Local Anesthetic				Seasonal			
Latex				Other:			

Please Explain Reaction:

	Y	N	?
Are you pregnant?			
Number of Weeks? ____			
Nursing?			
Taking birth control pills or hormonal replacement?			

Do you currently have or ever had a history of the following?

	Y	N	?		Y	N	?		Y	N	?		Y	N	?
Heart murmur				Asthma				Acid Reflux				Autoimmune disease			
Rheumatic fever				Emphysema				Ulcers				Arthritis			
Artificial heart valves				Tuberculosis				Hepatitis				Migraines			
High Blood Pressure				Thyroid				Liver Disease				AIDS or HIV			
Heart attack				Diabetes				Seizure				Sleep Disorder			
Pacemaker				Eating disorder				Kidney Disease				Sleep with CPAP			
Congestive heart failure				Depression				Fainting spells				Cancer			
Stroke				Anxiety				Clotting disorder/DVT				Radiation Therapy			

Please explain any "Yes" response AND list any condition not mentioned above that may be important to your health.

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 truth 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 inquiries 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 a action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/ Legal Guardian: **Date:**

X ____________________ ____________

For Completion by Dental Examiner

Comments: ____________________