



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) <input type="checkbox"/>		Cell Phone <input type="checkbox"/>		Work Phone <input type="checkbox"/>	
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	?	TMJ (Jaw Joint)	Y	N	?
Are you currently experiencing dental pain or discomfort?				Do you have frequent headaches or neck pains?			
				Do you clench or grind your teeth?			
Are your teeth sensitive to cold, hot, sweets, or pressure?				Do you have any clicking, popping or discomfort in the jaw?			
Have you had any periodontal (gum) treatments?				Do you wear, or have you ever worn, a nighttime bitesplint or mouth guard?			
Have you ever had orthodontic treatment?				Do you wear dentures or partial dentures?			
Is your home on well water?				Were dental x-rays taken in the last 365 days?:			
Have you had any problems associated with previous dental treatment?				Date of your last dental appointment: What was done at that time?			
Have you ever had a serious injury or surgery to your head or mouth?				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

Do you have a general physician?	Y	N	?	Have you had a serious illness, operation or been hospitalized in the past 10 years?.....	Y	N	?
Physician Name:	Phone			If yes, what was the illness or problem?			
Address				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

Do you use tobacco / nicotine (smoke, chew, E-cigarettes)?	Y	N	?	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?.....	Y	N	?
How Long? _____	How much? _____						
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, <u>Fosamax</u> , <u>Boniva</u> , <u>Actonel</u> , <u>Zometa</u> , <u>Reclast</u> ?			
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:							
Do you currently have or ever had a history of the following?							
	Y	N	?		Y	N	?
Heart murmur				Asthma			
Rheumatic fever				Emphysema			
Artificial heart valves				Tuberculosis			
High Blood Pressure				Thyroid			
Heart attack				Diabetes			
Pacemaker				Eating disorder			
Congestive heart failure				Depression			
Stroke				Anxiety			
				Acid Reflux			
				Ulcers			
				Hepatitis			
				Liver Disease			
				Seizure			
				Kidney Disease			
				Fainting spells			
				Clotting disorder/DVT			
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 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: _____
