PATIENT REGISTRATION AND HEALTH HISTORY

IF THIS APPOINTMENT IS FOR AN ADULT, COMPLETE THIS BOX.

1

DATE

NAME NICKNAME

ADDRESS

CITY STATE ZIP

HOME TELEPHONE ( ) CELL NUMBER

BIRTH DATE AGE

MARRIED SINGLE DIVORCED WIDOWED

SOCIAL SECURITY NO.

OCCUPATION EMAIL ADDRESS

EMPLOYER

BUSINESS ADDRESS CITY

BUSINESS TELEPHONE ( ) EXT

YOUR SPOUSE:

NAME

OCCUPATION SSN . .

EMPLOYER

BUSINESS ADDRESS CITY

BUSINESS TELEPHONE ( ) EXT

IF THIS APPOINTMENT IS FOR A CHILD, COMPLETE THIS BOX.

CHILD'S NAME NICKNAME

ADDRESS

CITY STATE ZIP

HOME PHONE NO. ( )

BIRTH DATE AGE GROUP

SCHOOL

IF YOUR CHILD'S NAME AND ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE ABOVE BOX ALSO.

2

DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE CO.

EMPLOYEE

PT. RELATION TO EMPLOYEE SELF SPOUSE CHILD

GROUP NO.

I.D. NO.

EMPL. BIRTH DATE

EMPL. SOCIAL SECURITY NO.

SECONDARY CARRIER

INSURANCE CO.

EMPLOYEE

RELATION TO PATIENT SELF SPOUSE CHILD

GROUP NO.

I.D. NO.

EMPL. BIRTH DATE

EMPL. SOCIAL SECURITY NO.

TO INSURE THAT YOUR INSURANCE IS FILED CORRECTLY, YOU ARE RESPONSIBLE FOR BRINGING INSURANCE FORMS FOR EACH VISIT. PAYMENT FOR YOUR ESTIMATED PORTION OF CHARGES (INCLUDING ANY DEDUCTIBLES) ARE DUE THE DAY OF SERVICE.

WE WILL FILE THE INITIAL INSURANCE CLAIM AT NO CHARGE. ADDITIONAL SUBMISSIONS ARE SUBJECT TO SERVICE CHARGES. ALTHOUGH WE ACCEPT INSURANCE ASSIGNMENT OF BENEFITS, YOU ARE RESPONSIBLE FOR THE ENTIRE ACCOUNT BALANCE (INCLUDING SERVICE CHARGES THAT MAY RESULT FROM INSURANCE DELAYS IN PAYMENT).

3

GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY A PATIENT AT OUR OFFICE ?

THEIR NAME:

REFERRED TO US BY:

4

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

❑ CHECK HERE IF SAME AS ABOVE

NAME

HOME ADDRESS

CITY STATE ZIP

EMPLOYER

EMPLOYER ADDRESS

CITY STATE ZIP

HOME PHONE ( )

BUSINESS PHONE ( )

SSN OF PERSON RESPONSIBLE

SPOUSE SSN:

Please see other side for health history information.

Thank You,
RANDY DANIEL, D.D.S.

THIS INFORMATION IS CONFIDENTIAL.

Do you have or have you had any of the following problems or diseases?

Yes	No	I. CARDIOVASCULAR SYSTEM
❑	❑	A. High Blood Pressure
❑	❑	B. Stroke
❑	❑	C. Rheumatic Fever/Heart Disease
❑	❑	D. Heart Attack/MI
❑	❑	E. Chest Pain/Angina
❑	❑	F. Heart Defects or Murmurs
❑	❑	G. Heart Surgery
❑	❑	1. Pacemaker
❑	❑	2. Prosthetic Valve
❑	❑	3. Bypass
❑	❑	4. Other
❑	❑	H. Other
		II. RESPIRATORY SYSTEM
❑	❑	A. Asthma
❑	❑	B. Emphysema
❑	❑	C. Tuberculosis
❑	❑	D. Shortness of Breath
❑	❑	E. Persistant Cough
❑	❑	F. Use Tobacco
❑	❑	G. Other

Yes	No	III. ENDOCRINE SYSTEM
❑	❑	A. Diabetes
❑	❑	B. Thyroid Disease
❑	❑	C. Adrenal Gland Disorders
❑	❑	D. Other
		IV. HEMATOPOIETIC SYSTEM
❑	❑	A. Anemia
❑	❑	B. Bleeding Disorders
❑	❑	C. Leukemia
❑	❑	D. Auto Immune Deficiency Syndrome (Aids)
❑	❑	E. Other
		V. GENITOURINARY SYSTEM
❑	❑	A. Kidney Infections
❑	❑	B. Bladder Infections
❑	❑	C. Genital Herpes
❑	❑	D. Venereal Disease
❑	❑	E. Other

Yes	No	VI. NEUROLOGICAL SYSTEM
❑	❑	A. Seizures
❑	❑	B. Epilepsy
❑	❑	C. Fainting Spells
❑	❑	D. Convulsions
❑	❑	E. Paralysis
❑	❑	F. Psychiatric Treatment
❑	❑	B. Other
		VII. GASTROINTESTINAL/LIVER
❑	❑	A. Ulcers
❑	❑	B. Bleeding
❑	❑	C. Hepatitis
❑	❑	D. Jaundice
❑	❑	E. Cirrhosis
❑	❑	F. Other
		VIII. MUSCULOSKELETAL SYSTEM
❑	❑	A. Prosthetic Hip
❑	❑	B. Osteoporosis
❑	❑	C. Degenerative Muscular Disease
❑	❑	D. Other

Are you taking any of the following medications?

Yes	No		Yes	No		Yes	No	
❑	❑	A. Anticoagulants (Blood Thinners)	❑	❑	F. Medicine for High Blood Pressure	❑	❑	K. Medications for Heart Condition
❑	❑	B. Aspirin/Tylenol	❑	❑	G. Insulin, Tolbutamide (Orinase)	❑	❑	L. Medications for Allergies
❑	❑	C. Antibiotics or Sulfa Drugs	❑	❑	H. Thyroid Medication	❑	❑	M. Other
❑	❑	D. Corticosteroids	❑	❑	I. Digitalis			
❑	❑	E. Tranquilizers	❑	❑	J. Nitroglycerin			

Are You Allergic to or Have You Reacted Adversely to:

Yes	No		Yes	No		Yes	No	
❑	❑	A. Penicillin	❑	❑	E. Barbiturates, Sedatives or Sleeping Pills	❑	❑	J. Propoxyphene(Darvon)
❑	❑	B. Tetracycline				❑	❑	K. Demerol
❑	❑	C. Any Other Antibiotics (Emycin, Keflex or Sulfa)	❑	❑	F. Aspirin	❑	❑	L. Other Medications
			❑	❑	G. Acetaminophen (Tylenol)	❑	❑	M. Foods, Dust, Pollens, etc.
❑	❑	D. Local Anesthetics (Novacaine, Lidocaine, Carbocaine, Marcaine	❑	❑	H. Ibuprofen (Motrin, Advil, Nuprin)	❑	❑	N. Other
			❑	❑	I. Codeine			

Yes	No	
❑	❑	1. Are you presently under the care of a physician?
		Why?_____
❑	❑	2. Have you ever been told that you have a tumor of malignancy?
		What?_____Where?_____
		When?_____Treatment_____
❑	❑	3. Have you ever had any serious trouble with previous dental treatment? Describe_____
❑	❑	4. In general, do dental treatments make you tense or cause you to worry?
❑	❑	5. Are you dissatisfied with the appearance of your teeth? Why?_____
❑	❑	6. Do your gums bleed easily when you brush? Where?_____
❑	❑	7. Do you have a tooth or teeth that frequently feel loose? Where?_____
❑	❑	8. Have you ever suffered a severe blow to the face, chin or jaws? When?_____
❑	❑	9. Do you notice popping, clicking or soreness in your jaw joints (in front of your ears)?
❑	❑	10. Do you find it difficult to sometimes open wide?
❑	❑	11. Are you aware you are clenching or grinding your teeth? When?_____
❑	❑	12. Is there anything we should know about your general health or dental condition before we proceed? If so describe in your own words.

When did you last have your teeth cleaned?_____

PHYSICIAN'S NAME and PHONE NUMBER:

I authorize release of any medical records deemed necessary which may aid in my dental treatment.

Signature_____ Date_____