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COMPREHENSIVE DENTISTRY

# REGISTRATION AND HEALTH HISTORY

Name: _____ Social Security #: _____

Name we should call you: _____ Date of Birth:_____

Home Phone #: _____Cell #: _____ E-mail Address: _____

Address: _____

Employed By:_____

Position: _____ Work Phone# _____

Marital Status: _____ Spouse's Name:_____

Spouse's SS#: _____ Spouse's Date of Birth:_____

Spouse Employed By:_____

Position: _____ Work Phone#: _____

Nearest Relative (In case of emergency): _____

Phone #: _____ City & State: _____

Who may we thank for referring you to our practice? _____

Who will pay your account? _____

Purpose of this visit:_____

**INSURANCE INFORMATION:**

Name of Primary Dental Insurance Company:_____
Name of Employee/Policy Holder: _____ Group #: _____
Member/Subscriber/Employee # (If Applicable) _____

**MEDICAL HISTORY:**

Name & phone # of Primary Care Physician: _____
Date of your last complete physical: _____
Are you taking any medication, pills, drugs, vitamins or supplements now? _____ If so, list them below:

| **Name of Medication/Drug/Supplement:** | **Purpose/Reason:** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

# Initial Visit Interview

- ❑ Dr.
- ❑ Mr.
- ❑ Mrs.
- ❑ Miss
- ❑ Ms._____ Date _____
  Last First Middle Initial

*Your answers to this dental history questionnaire will help us understand your specific dental problems, so that we may effectively treat you with consideration for your individual needs.*

Previous Dentist _____ Specialty _____

Period of Treatment _____ Date of Last Visit _____

Address _____
Number Street City State Zip Code (area code) Phone

What is your immediate dental concern? _____

_____

**Please check YES or NO (or circle one).**

1) I think I am:
   - ❑ In Excellent oral health.
   - ❑ In Good oral health.
   - ❑ In Poor oral health.
2) I desire:
   - ❑ Excellent oral health.
   - ❑ Average or Good oral health.
   - ❑ Crisis Care only.
3) Are you presently in pain? **YES** or **NO**
   - ❑ Teeth
   - ❑ Gums
   - ❑ Jaw
   - ❑ Face
   - ❑ Other _____
4) Is any part of your mouth sensitive to the following? **YES** or **NO**
   - ❑ Hot
   - ❑ Cold
   - ❑ Sweet
   - ❑ Sour
   - ❑ Pressure
   - ❑ Other _____

5) Do you have a burning sensation in your mouth? **YES** or **NO**
6) Are you troubled with dryness in your mouth? **YES** or **NO**
7) Do you have any pain or soreness around your ears, cheeks, or other parts of your face? **YES** or **NO**
8) Do you have chronic headaches? **YES** or **NO**
9) Have you ever had periodontal treatment or gum surgery? **YES** or **NO**
If Yes, when? _____ By Whom? _____
10) Have you ever been informed of any gum problems? **YES** or **NO**
If Yes, when? _____ By Whom? _____
11) Do your gums bleed when you brush your teeth? **YES** or **NO**
12) Does food catch between your teeth? **YES** or **NO**
13) Do you drink sodas/pop? **YES** or **NO**
14) Are you aware of a bad taste or odor in your mouth? **YES** or **NO**
15) Please indicate which items you use daily.
- ❑ Hard-bristle toothbrush
- ❑ Soft-bristle toothbrush
- ❑ Electric toothbrush
- ❑ Proxi-brush
- ❑ Rubber Tip
- ❑ Dental Floss
- ❑ Water Spray
- ❑ Stimudents or toothpicks
- ❑ Other _____

16) Are you aware of any growths or swelling in your mouth? **YES** or **NO**
If Yes, Where are they located and how long have they existed? _____
_____
17) Do you have frequent cold sores, canker sores, or fever blisters on your gums, cheeks or lips? **YES** or **NO** If Yes, how often? _____
18) Are you aware of your jaw clicking, popping, or making grating-like noises? **YES** or **NO** If Yes, when? _____
19) Do your jaw muscles feel tired, stiff or painful? **YES** or **NO**
20) Do you chew gum? **YES** or **NO**
21) Are you aware of clenching your teeth during the day? **YES** or **NO** If Yes, how often?
_____
22) Have you ever been told that you grind your teeth during your sleep? **YES** or **NO** If Yes, how often? _____
23) Do you wear a removable denture or appliance? **YES** or **NO** If Yes, when do you wear it? _____
24) Are you frustrated by needing constant dental repair because of active dental disease? **YES** or **NO**
25) Are you anxious about dental treatment? **YES** or **NO**
26) Do you have any disease or known condition which has not been addressed in the above. That you feel is important for us to know? If Yes, please explain: _____

27) My mouth is:
- ❑ Very Comfortable.
- ❑ Moderately Comfortable.
- ❑ Uncomfortable.

28) I:
- ❑ Think the appearance of my mouth is excellent.
- ❑ Think the appearance of my mouth is adequate.
- ❑ Wish I could change the appearance of my mouth.
  If so, what would you change? _____

  _____

29) I:
- ❑ Want to save my teeth at all costs.
- ❑ Prefer to keep my teeth if cost and time are reasonable.
- ❑ Am not very interested in setting personal goals to achieve optimum oral health.

30) I:
- ❑ Have followed the recommendations for optimum dental health given by my dentist.
- ❑ Have not done what dentists recommended I do with my mouth.
- ❑ Usually only go to the dentist for emergencies.

31) What are some questions about dentistry and your oral health that you have never had adequately answered? _____

_____

_____

As it relates to my medical history, all of the preceding answers are true and correct to the best of my knowledge. If I ever have a change in my health, or if my medications change, I will inform Dr. Hatcher or his staff at my next dental appointment without fail. (Insurance patients only: I authorize release of any information relating to dental insurance claims.) I understand that I am responsible for all costs of dental treatment and that before credit is extended, a credit report will be obtained.

Signature _____ Date _____

# MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No _____

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive ◯ Yes ◯ No | Cortisone Medicine ◯ Yes ◯ No | Hemophilia ◯ Yes ◯ No | Renal Dialysis ◯ Yes ◯ No |
| Alzheimer's Disease ◯ Yes ◯ No | Diabetes ◯ Yes ◯ No | Hepatitis A ◯ Yes ◯ No | Rheumatic Fever ◯ Yes ◯ No |
| Anaphylaxis ◯ Yes ◯ No | Drug Addiction ◯ Yes ◯ No | Hepatitis B or C ◯ Yes ◯ No | Rheumatism ◯ Yes ◯ No |
| Anemia ◯ Yes ◯ No | Easily Winded ◯ Yes ◯ No | Herpes ◯ Yes ◯ No | Scarlet Fever ◯ Yes ◯ No |
| Angina ◯ Yes ◯ No | Emphysema ◯ Yes ◯ No | High Blood Pressure ◯ Yes ◯ No | Shingles ◯ Yes ◯ No |
| Arthritis/Gout ◯ Yes ◯ No | Epilepsy or Seizures ◯ Yes ◯ No | Hives or Rash ◯ Yes ◯ No | Sickle Cell Disease ◯ Yes ◯ No |
| Artificial Heart Valve ◯ Yes ◯ No | Excessive Bleeding ◯ Yes ◯ No | Hypoglycemia ◯ Yes ◯ No | Sinus Trouble ◯ Yes ◯ No |
| Artificial Joint ◯ Yes ◯ No | Excessive Thirst ◯ Yes ◯ No | Irregular Heartbeat ◯ Yes ◯ No | Spina Bifida ◯ Yes ◯ No |
| Asthma ◯ Yes ◯ No | Fainting Spells/Dizziness ◯ Yes ◯ No | Kidney Problems ◯ Yes ◯ No | Stomach/Intestinal Disease ◯ Yes ◯ No |
| Blood Disease ◯ Yes ◯ No | Frequent Cough ◯ Yes ◯ No | Leukemia ◯ Yes ◯ No | Stroke ◯ Yes ◯ No |
| Blood Transfusion ◯ Yes ◯ No | Frequent Diarrhea ◯ Yes ◯ No | Liver Disease ◯ Yes ◯ No | Swelling of Limbs ◯ Yes ◯ No |
| Breathing Problem ◯ Yes ◯ No | Frequent Headaches ◯ Yes ◯ No | Low Blood Pressure ◯ Yes ◯ No | Thyroid Disease ◯ Yes ◯ No |
| Bruise Easily ◯ Yes ◯ No | Genital Herpes ◯ Yes ◯ No | Lung Disease ◯ Yes ◯ No | Tonsillitis ◯ Yes ◯ No |
| Cancer ◯ Yes ◯ No | Glaucoma ◯ Yes ◯ No | Mitral Valve Prolapse ◯ Yes ◯ No | Tuberculosis ◯ Yes ◯ No |
| Chemotherapy ◯ Yes ◯ No | Hay Fever ◯ Yes ◯ No | Pain in Jaw Joints ◯ Yes ◯ No | Tumors or Growths ◯ Yes ◯ No |
| Chest Pains ◯ Yes ◯ No | Heart Attack/Failure ◯ Yes ◯ No | Parathyroid Disease ◯ Yes ◯ No | Ulcers ◯ Yes ◯ No |
| Cold Sores/Fever Blisters ◯ Yes ◯ No | Heart Murmur ◯ Yes ◯ No | Psychiatric Care ◯ Yes ◯ No | Venereal Disease ◯ Yes ◯ No |
| Congenital Heart Disorder ◯ Yes ◯ No | Heart Pace Maker ◯ Yes ◯ No | Radiation Treatments ◯ Yes ◯ No | Yellow Jaundice ◯ Yes ◯ No |
| Convulsions ◯ Yes ◯ No | Heart Trouble/Disease ◯ Yes ◯ No | Recent Weight Loss ◯ Yes ◯ No | |

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____