

DENTAL REGISTRATION AND HEALTH HISTORY

			Date										
Patients Name		How do you prefer	to be addressed?										
Sex: M F Age:Birth Date:	/ /	_	SS	SS#									
Mailing Address		City	State	Zip									
Home #:	Cell#:												
Employer:		Occupation:											
If Student, name of School / College:		City	State	Part Time or Full Time									
Email Address:	il Address:Whom may we thank for referring you to our office:												
If the person responsible for thi party must fill out the s	-	-	•										
Name of responsible party	Relationship to Patient												
Mailing Address		City	State	Zip									
Sex: M F Age:Birth Date:	/ /	SS#											
Home #:	Cell#:		_Work#:										
Email Address:	Employ	ver:	Occupation:										
	INSUR	ANCE INFORMA	ΓΙΟΝ										
Policy Holders Name	Relationship to Patient												
Social Security and/or Member ID #			Date of Birth	1 1									
Name of Employer		Employer Address											
Insurance Co	Phone #	<u> </u>	Group #										
	Seconda	ry Insurance Infor	mation										
Policy Holders Name		Relationship	o to Patient										
Social Security and/or Member ID #			Date of Birth	1 1									
Name of Employer		Employer Address											
Insurance Co.	Phone #	<u> </u>	Group #										
Answers to the following questions are	e for our records only a	and will be considered	confidential.										

ALLERGIES MEDICATIONS

Codeine Metals Latex Other: Place a mark on YES or No to indicate if your have had any of the following: Chest Pain VFS NO Hepatitis A (Infectious) VFS NO Drug addictions VFS NO Heart Disease or Attack VFS NO Hepatitis R (Serum) VFS NO Drug addictions VFS NO Heart Disease or Attack VFS NO Hepatitis R (Serum) VFS NO Drug addictions VFS NO Othersprosisotroperia VFS NO Hepatitis R (Serum) VFS NO Psychiatric Treatment VFS NO Hepatitis R (Serum) VFS NO Psychiatric Treatment VFS NO Heart Surgery VFS NO HIV positive, ARC, AIDS VFS NO Birth Defects VFS NO HiV positive, ARC, AIDS VFS NO Birth Defects VFS NO HiV positive, ARC, AIDS VFS NO Birth Defects VFS NO HiV positive, ARC, AIDS VFS NO Birth Defects VFS NO HiV positive, ARC, AIDS VFS NO Birth Defects VFS NO HiV positive, ARC, AIDS VFS NO Birth Defects VFS NO HiV positive, ARC, AIDS VFS NO Birth Defects VFS NO High Blood Pressure VFS NO Liver Disease VFS NO Fainting or dizzy spells VFS NO High Blood Pressure VFS NO Liver Disease VFS NO Fainting or dizzy spells VFS NO High Blood Pressure VFS NO Kidney Trouble VFS NO Psychiatric Cough VFS NO Hiver Disease VFS NO Psychiatric Cough VFS NO Hiver Defease VFS NO Psychiatric Cough VFS NO Hiver Disease VFS NO Psychiatric Cough VFS NO Hiver Disease VFS NO Psychiatric Cough VFS NO Psychiatric Cough VFS NO Hiver Defease VFS NO Psychiatric Cough VFS NO Hiver Defease VFS NO Psychiatric Cough VFS NO Hiver Defease VFS NO Psychiatric Cough VFS	•			Please list any medications you are currently taking:						
Place a mark on VES or No to indicate if you have had any of the following: Chest Pain YES NO Hepatitis A (Infectious) YES NO Hepatitis No Hepatitis (Berrum) YES NO Hepatitis No Hepatiti	Codeine	Sulfa								
Place a mark on VES or No to indicate if you have had any of the following: Chest Pain YES NO Hepatitis A (Infectious) YES NO Heart Disease or Attack YES NO Hepatitis (Serum) YES NO Heart Disease or Attack YES NO Hepatitis (Serum) YES NO Heart Disease or Attack YES NO Hepatitis (Serum) YES NO Hepatitis (Serum) YES NO Alcoholism YES NO Here Disease or Attack YES NO Hispatitis (Serum) Y	Iodine	Metals								
Chest Pain VFS NO Hepatitis A (Infectious) VFS NO Use of tobacco products VFS NO Heart Failure VFS NO Hepatitis (Rerum) VFS NO Drug addictions VFS NO Osteoprosiosteepenia VFS NO Hepatitis (Rerum) VFS NO Drug addictions VFS NO Osteoprosiosteepenia VFS NO Tuberculosis (TB) VFS NO Psychiatric Treatment VFS NO Osteoprosiosteepenia VFS NO Tuberculosis (TB) VFS NO Psychiatric Treatment VFS NO Heart Surgery VFS NO HUP positive, ARC, AIDS VFS NO Psychiatric Treatment VFS NO Sickla Cell Disease VFS NO Bishosphonate VFS NO Compenial Heart Problems VFS NO Emphysema VFS NO Bishosphonate VFS NO Emphysema VFS NO Emphysema VFS NO Enghysema VF	Latex	Other:								
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Heart Surgery YES NO Bity Positive, ARC, AIDS YES NO Bisphosphonate YES NO Sited Cell Disease YES NO Birth Defects YES NO Cognital Heart Problems YES NO Emphysema YES NO Enting Disorder YES NO Platent Disorder YES NO Liver Disease YES NO Enting Disorder YES NO Platent Problems YES NO Liver Disease YES NO Enting Disorder YES NO Problems YES NO Dispersion YES NO Dispersion YES NO Enting Disorder YES NO Problems YES NO Enting Problems YES NO Problems YES NO Enting Problems YES NO E					-					
*Mitral Valve Prolapse	• •	ia			` /			•		
*Congenital Heart Problems VES NO Emphysema VES NO Eating Disorder VES NO Place Heart Murmur VES NO Liver Disease VES NO Eating or dizzy spells VES NO High Blood Pressure VES NO Liver Disease VES NO Epitepsy or scizures VES NO Heart Pacemaker VES NO Thyroid Disease VES NO Epitepsy or scizures VES NO Cancer (Type: No Nidney Trouble VES NO Asthma VES NO Cancer (Type: VES NO Henophilia VES NO Asthma VES NO Cancer (Type: VES NO Henophilia VES NO Shortness of Breath VES NO Cancer (Type: VES NO Jaundice VES NO Henophilia VES NO Shortness of Breath VES NO Chemotherapy VES NO Anemia VES NO High VES NO Chemotherapy VES NO Anemia VES NO High VES NO High VES NO WES NO High VES NO WES	٠,				•					
*Heart Murmur YES NO Diabetes YES NO Fighleps or seizures YES NO High Blood Pressure YES NO Liver Disease YES NO Fpileps or seizures YES NO Heart Pacemaker YES NO Thyroid Disease YES NO Persistent Cough YES NO Stroke YES NO Kidney Trouble YES NO Asthma YES NO Radiation Therapy YES NO Hemophilia YES NO Shortness of Breath YES NO Cancer (Type:) YES NO Jaundice YES NO Hortess of Breath YES NO Chemotherapy YES NO Jaundice YES NO Hives or Skin Rash YES NO Chemotherapy YES NO Jaundice YES NO Hives or Skin Rash YES NO Hortes Hortes YES NO Hortes YES NO Hortes Hortes YES NO Hortes Hortes YES NO Hortes YES NO Hortes YES NO Hortes Hortes YES NO Hortes Hortes Hortes YES NO Hortes YES NO Hortes YES NO Hortes YES NO Hortes Hortes Hortes YES NO Hortes Ho	-		YES	NO	Sickle Cell Disease		NO	Birth Defects	YES	NO
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Rearr Pacemaker YES NO Thyroid Disease YES NO Persistent Cough YES NO	*Heart Murmur		YES	NO	Diabetes	YES	NO	Fainting or dizzy spells	YES	NO
Stroke YES NO Kidney Trouble YES NO Asthma YES NO Cancer (Type:) YES NO Hemophilia YES NO Shortness of Breath YES NO Radiation Therapy YES NO Jaundice YES NO Hay Fever YES NO Chemotherapy YES NO Jaundice YES NO Hay Fever YES NO Chemotherapy YES NO Jaundice YES NO Hives or Skin Rash YES NO Shortness of Breath YES NO Chemotherapy YES NO Chemotherapy YES NO Glaucoma YES NO Hives or Skin Rash YES NO Shortness of Breath YES NO Chemotherapy YES NO			YES	NO	Liver Disease	YES	NO	Epilepsy or seizures	YES	NO
Cancer (Type:) YES NO Hemophilia YES NO Shortness of Breath YES NO Radiation Therapy YES NO Jaundice YES NO Hay Fever YES NO Chemotherapy YES NO Anemia YES NO Hay Fever YES NO Chemotherapy YES NO Anemia YES NO Sinus Trouble YES NO Sinus Trouble YES NO Sinus Trouble YES NO Artificial Joints YES NO Ulcers YES NO Cold Sores YES NO Type Artificial Joints YES NO Hay Fever YES NO Type Artificial Joints YES NO Hay Fever YES NO Type Artificial Joints YES NO Blood Transfusion YES NO Bruise Easily YES NO Type Artificial Joints YES NO Blood Transfusion YES NO Type Artificial Joints YES NO Blood Transfusion YES NO Type YES NO Type Artificial Joints YES NO Type YES NO Type Artificial Joints YES NO Artificial Joints YES NO	Heart Pacemaker		YES	NO	Thyroid Disease	YES	NO	Persistent Cough	YES	NO
Radiation Therapy YES NO Anemia YES NO Hay Fever YES NO His Fever YES NO Blood Transfusion YES NO Bruise Easily YES NO YES NO OTHER: *Antibiotic pre-medication may be required prior to your appointment Have you been advised by your Physician to "Pre-Medicate" for dental appointments? YES NO WOMEN: Are you pregnant now? YES NO WOMEN: Are you pregnant now? YES NO If yes, what is your due date? YES NO Icertify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental gruin surance benefits of therwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Signature of Dentist	Stroke		YES	NO	Kidney Trouble	YES	NO	Asthma	YES	NO
Chemotherapy YES NO Anemia Steroid Treatment YES NO Glaucoma NES NO Simus Trouble YES NO Artificial Joints YES NO Arthritis YES NO Herpes YES NO Arthritis YES NO Herpes YES NO Any Type of Transplant: YES NO Ulcers Any Type of Transplant: YES NO Angina Pectoris YES NO Blood Transfusion YES NO Blood Transfusion YES NO Bruise Easily YES NO TOTHER: *Antibiotic pre-medication may be required prior to your appointment Have you been advised by your Physician to "Pre-Medicate" for dental appointments? YES NO WOMEN: Are you pregnant now? YES NO If yes, what is your due date? YES NO Icertify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/ or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance conflicts on the day on the precious of such dental care to third party payors and/ or health practitioners. I authorize and and request my insurance company to pay directly to the dentist or dental group insurance conflicts or health practitioners. I authorize and are quest my insurance company to pay directly to the dentist or dental group insurance conflicts or health practitioners. I authorize and are quest my insurance company to pay directly to the dentist or dental group insurance conflicts rendered on my dependents. Signature of Dentist	Cancer (Type:) YES	NO	Hemophilia	YES	NO	Shortness of Breath	YES	NO
*Artificial Joints YES NO Glaucoma YES NO Ginus Trouble YES NO Arthritis YES NO Herpes YES NO Any Type of Transplant: YES NO Ulcers YES NO Cold Sores YES NO Type *Any Type of Implant: Type YES NO Angina Pectoris YES NO Bruise Easily YES NO OTHER: *Any Type of Implant: Type YES NO Angina Pectoris YES NO Bruise Easily YES NO OTHER: *Antibiotic pre-medication may be required prior to your appointment Have you been advised by your Physician to "Pre-Medicate" for dental appointments? *WOMEN: Are you pregnant now? *Are you currently breast feeding? Are you currently breast feeding? Are you currently breast feeding? YES NO I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental proposed proposed in the practitioners payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.	Radiation Therapy		YES	NO	Jaundice	YES	NO	Hay Fever	YES	NO
*Artificial Joints YES NO Ulcers YES NO Cold Sores YES NO Type of Transplant: YES NO Ulcers YES NO Cold Sores YES NO Type of Transplant: YES NO Ulcers YES NO Cold Sores YES NO Type of Transplant: YES NO Angina Pectoris YES NO Bruise Easily YES NO Bruise Easily YES NO THER: *Antibiotic pre-medication may be required prior to your appointment Have you been advised by your Physician to "Pre-Medicate" for dental appointments? YES NO WOMEN: Are you pregnant now? YES NO If yes, what is your due date? Are you currently breast feeding? YES NO Types NO I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such actal care to third party payors and/ or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Signature of Dentist	Chemotherapy		YES	NO	Anemia	YES	NO	Hives or Skin Rash	YES	NO
*Any Type of Transplant: YES NO Ulcers YES NO Cold Sores YES NO Type Of Implant: Type YES NO Angina Pectoris YES NO Bruise Easily YES NO Bruise Easily YES NO The West of Transfusion YES NO Blood Transfusion YES NO The West of Transfusion YES NO The West of Transfusion Type of Implant: Type YES NO Blood Transfusion YES NO The West of Transfusion YES NO The West of Transfusion Type of Implant: Type YES NO Blood Transfusion YES NO The West of Transfusion Type of Transfusion YES NO The West of Transfusion Type of Transfusion Type of Transfusion Type of Transfusion Type of Transfusion YES NO The West of Transfusion	*Steroid Treatment		YES	NO	Glaucoma	YES	NO	Sinus Trouble	YES	NO
Type 'Any Type of Implant: Type 'YES NO Angina Pectoris YES NO Bruise Easily YES NO **Rheumatic Fever YES NO Blood Transfusion YES NO **The Rheumatic Fever YES NO Blood Transfusion YES NO **The Rheumatic Fever YES NO Blood Transfusion YES NO **The Rheumatic Fever YES NO Blood Transfusion YES NO **The Rheumatic Fever YES NO **The Rheu	*Artificial Joints		YES	NO	Arthritis	YES	NO	Herpes	YES	NO
*Any type of Implant: Type VES NO Angina Pectoris VES NO Blood Transfusion YES NO OTHER: *Antibiotic pre-medication may be required prior to your appointment Have you been advised by your Physician to "Pre-Medicate" for dental appointments? YES NO WOMEN: Are you pregnant now? YES NO If yes, what is your due date? Are you currently breast feeding? YES NO I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Signature of Dentist Signature of Dentist	*Any Type of Transp	lant:	YES	NO	Ulcers	YES	NO	Cold Sores	YES	NO
*Antibiotic pre-medication may be required prior to your appointment Have you been advised by your Physician to "Pre-Medicate" for dental appointments? WOMEN: Are you pregnant now? Are you currently breast feeding? Are you taking oral contraceptives? I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Signature of Dentist Signature of Dentist		t. Type	VEC	NO	Angina Pastaris	VEC	NO	Druise Fesily	VEC	NO
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Signature of Dentist	Signature of patie	ent or 91	uardian							
	z.g.mme oj punc	or gr								
Date:	Signature of Dentist									
	Date:									