CHART ID#______

HEALTH HISTORY & REGISTRATION

PATIENT'S NAME: Last______________________ First______________________ Middle__________

ADDRESS:______________________________ CITY, STATE, ZIP______________________

HOME PHONE:______________ WORK PHONE:______________ CELL / PAGER______________

SEX: M F BIRTH DATE ____/____/____ AGE_____ SOC. SEC.#______________

MARITIAL STATUS: __________ DRIVER'S LICENSE #______________ EMAIL:______________

EMPLOYER______________ OCCUPATION______________ # OF YEARS EMPLOYED_____

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN THE PATIENT) RELATION TO PATIENT______________

PATIENT'S NAME: Last______________________ First______________________ Middle__________

ADDRESS:______________________________ CITY, STATE, ZIP______________________

HOME PHONE:______________ WORK PHONE:______________ CELL / PAGER______________

BIRTH DATE ____/____/____ SOC. SEC.#______________ DRIVER'S LICENSE #______________

RESPONSIBLE PARTY IS ALSO ☐ PRIMARY INSURANCE POLICY HOLDER ☐ SECONDARY INSURANCE POLICY HOLDER

PRIMARY INSURANCE INFORMATION

NAME OF INSURED: ______________________

EMPLOYER: ______________________

EMPLOYER'S ADDRESS: ______________________

INSURANCE COMPANY: ______________________

INS. COMPANY ADDRESS: ______________________

SECONDARY INSURANCE INFORMATION

NAME OF INSURED: ______________________

EMPLOYER: ______________________

EMPLOYER'S ADDRESS: ______________________

INSURANCE COMPANY: ______________________

INS. COMPANY ADDRESS: ______________________

It is important that we know about your Medical history. These facts have a direct bearing on your dental health. This information is strictly confidential and will not be released to anyone without your permission. Thank you for answering the following questions.

	YES	NO	N/A	
Are you under a physician's care?	☐	☐	☐	______
Have you ever been hospitalized or had a major operation?	☐	☐	☐	______
Are you taking medications, pills, or drugs?	☐	☐	☐	______
Do you take, or have taken, Phen-Fen or Redux?	☐	☐	☐	______
For women: are you pregnant?	☐	☐	☐	______
Do you use cigars/cigarettes, pipe, or chewing tobacco?	☐	☐	☐	______
Do you use controlled substances?	☐	☐	☐	______

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Latex ☐ Metal ☐ Local Anesthetics ☐ Other ______________

Do you have, or had any of the following?

	YES	NO		YES	NO		YES	NO
AIDS/HIV Positive	☐	☐	Heart Disease/Attack	☐	☐	Bruise Easily	☐	☐
Angina Pectoris	☐	☐	Hepatitis A (infectious)	☐	☐	Emphysema	☐	☐
High Blood Pressure	☐	☐	Hepatitis B (serum)	☐	☐	Tuberculosis	☐	☐
Heart Murmur	☐	☐	Hepatitis C	☐	☐	Asthma	☐	☐
Rheumatic Fever	☐	☐	Liver Disease	☐	☐	Hay Fever	☐	☐
Congenital Heart Lesions	☐	☐	Blood Transfusion	☐	☐	Sinus Troubles	☐	☐
Mitral Valve Prolapse	☐	☐	Drug Addiction	☐	☐	Allergies or Hives	☐	☐
Artificial Heart Valve	☐	☐	Hemophilia (Bleeding Problem)	☐	☐	Diabetes	☐	☐
Heart Pacemaker	☐	☐	Fever Blisters	☐	☐	Thyroid Disease	☐	☐
Heart Surgery	☐	☐	Epilepsy or Seizures	☐	☐	Radiation Therapy	☐	☐
Artificial Joints (Hip, Knee)	☐	☐	Nervousness	☐	☐	Arthritis	☐	☐
Anemia	☐	☐	Psychiatric treatment	☐	☐	Cortisone Medicine	☐	☐
Stroke	☐	☐	Glaucoma	☐	☐	Pain in Jaw Joints	☐	☐
Kidney Trouble	☐	☐	Chemotherapy	☐	☐	Alcoholism	☐	☐
Ulcers	☐	☐	Venereal Disease	☐	☐	Cosmetic Surgery	☐	☐

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 the patient's health.

Signature of Patient, Parent, or Guardian______________________ Date:__________ Dentist Signature______________