Dental Registration and Health History

Name: ________________________________ Date: _____________________

Home Phone: ______________________ Cell Phone: ___________________ Work #: __________________

Home street address: _________________________________ City: _______________________________

State: __________________ Zip code: _______________ Social Security #___________________

Date of Birth:__________________________ E-mail Address:____

[ ] Male [ ] Female Marital status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Employer _______________________________ Occupation _______________________________

Spouse/partner's name ____

Whom may we thank for referring you? ____

Insurance Information:

Are you covered by dental insurance? [ ] Yes [ ] No

Subscriber Name: ________________________________ Relation to Patient: ___________________________

Subscriber Birth Date: ____________________

Address & phone *(If different from patient):* ____

____

Insurance Company & address: ____

____

Subscriber Employed by: ____________________________ Business Phone: ______________________________

ID # (listed on insurance card): ______________________

Do you have secondary insurance? [ ] Yes [ ] No

If yes:

Subscriber Name: ________________________________ Relation to Patient: ___________________________

Subscriber Birth Date: ____________________

Address & phone *(If different from patient):* ____

____

Insurance Company & address: ____

____

Subscriber Employed by: ____________________________ Business Phone: ______________________________

ID # (listed on insurance card): ______________________

This form was developed by the Heart Attack & Stroke Prevention Center, the Bale/Doneen Method & Partners In Complete Health. Order more forms at www.partnersincompletehealth.org.

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Personal Health

How would you rate your current health? [ ] Excellent [ ] Good [ ] Fair [ ] Poor
Name and location of your current physician: ____
Date of your last physical exam: ______________________

Please indicate whether you have had any of the following medical problems
(Include dates to indicate when the problem occurred.

Check (✓) if you have had problems with any of the following:

- ❒ Bad Breath
- ❒ Periodontal treatment
- ❒ Bleeding gums
- ❒ Food collection between teeth
- ❒ Loose teeth or broken fillings
- ❒ Dry Mouth
- ❒ Grinding teeth
- ❒ Jaw pain or tiredness
- ❒ Pain around your ear
- ❒ Clicking or popping jaw
- ❒ Lip or cheek biting
- ❒ Sores or growths in your mouth
- ❒ Sensitivity to hot
- ❒ Sensitivity to cold
- ❒ Sensitivity to sweets
- ❒ Sensitivity when biting

Oral Health

Is there a specific dental problem that you currently have? ____
How many times per day do you brush your teeth? _______ What type of toothbrush do you use? __________________
Do you floss regularly? [ ] Yes [ ] No How often? ______________________
How often do you see your dentist? ___________________________ Do you ever have bleeding gums? [ ] Yes [ ] No
Does your oral health concern you? [ ] Yes [ ] No If yes, why? ____

Are you interested in: Whiter teeth? [ ] Yes [ ] No Reducing snoring? [ ] Yes [ ] No

Medications: Please list all prescription and non-prescription medications, vitamins, home remedies, and herbs.

Medications/ Supplements	*Dose (mg per pill, doses per day)*	*Start date*	*End date*

Allergies or reactions to:

- ❒ Aspirin
- ❒ Novocaine
- ❒ Penicillin/Amoxicillin
- ❒ Sulfa
- ❒ Latex

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❒ Other: ____

Please indicate whether you have had any of the following **medical problems**. Please include dates when they occurred.

Heart Disease [ ] __________
Stroke [ ] ___________
Heart Arrhythmia [ ] _________
Heart Valve Problem [ ] __________
High Cholesterol [ ] __________
High Blood Pressure [ ] __________
Pacemaker [ ] ___________
Arterial Fibrillation [ ] __________
Aortic Aneurysm [ ] __________
Brain Aneurysm [ ] ___________
Poor Blood Flow to extremities [ ] _________
Bleeding or clotting Problems [ ] __________
Blood Transfusions [ ] __________
Anemia [ ] ____________
High Red Blood Cell Count [ ] ___________
Leukemia [ ] __________
Abnormal Platelet Count [ ] _________
Pre-diabetes [ ] __________
Diabetes [ ] __________
Stomach Ulcers [ ] __________
Chronic Heartburn [ ] ___________
Gout [ ] ___________
Sleep Disorder [ ] ___________
Depression [ ] ___________
Post Traumatic Stress Syndrome [ ] __________
Suicide Attempts [ ] ___________
Blood Clots in Legs or Lungs [ ] __________
Thin Bones/Osteoporosis [ ] __________
Rheumatic Fever [ ] ___________

Kidney Disease [ ] ___________
Kidney Stones [ ] ___________
Gallbladder Stones [ ] ___________
Pancreatic Disease [ ] ___________
Hepatitis [ ] ___________
Fatty Liver [ ] ___________
Autoimmune disorder [ ] __________
Lupus [ ] ___________
Sjogren's Syndrome [ ] __________
History of HIV [ ] ___________
Rheumatoid Arthritis [ ] _________
Shortness of Breath [ ] __________
Tuberculosis [ ] _________
Epilepsy [ ] __________
Fainting or Dizziness [ ] _________
Vertigo [ ] ___________
Balance Issues [ ] _________
Thyroid Problems [ ] _________
Cancer [ ] ___________
Radiation Treatment [ ] __________
Chemotherapy [ ] ____________
Glaucoma [ ] ___________
Migraine Headaches [ ] ___________
Stress Headaches [ ] ___________
Sinus Infections [ ] __________
Eating Disorders [ ] ___________
Physical Disability [ ] __________
Mental Disability [ ] ___________
Drug Use [ ] ___________

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Social history

Tobacco use

Cigarettes: [ ] Never [ ] Quit: date you quit smoking _________ [ ]

Other tobacco (check all answers that apply): [ ] Pipe [ ] Cigar [ ] Chewing tobacco [ ] e-cigarettes [ ] Marijuana

Number of years you've used this tobacco _________

Are you interested in quitting? [ ] Yes [ ] No Have you tried to quit in the past [ ] Yes [ ] No

How many times have you tried to quit? _________ What methods have you tried? ____________________________

Are you exposed to second-hand smoke? [ ] Yes [ ] No If yes, for how long? ______________________

Alcohol use

Have you been treated for Alcoholism? [ ] Yes [ ] No

History for women

Do you have osteoporosis (bone loss)? [ ] Yes [ ] No osteopenia (bone thinning)? [ ] Yes [ ] No

Menopause? [ ] Yes [ ] No

Hysterectomy? [ ] Yes [ ] No When ____________ Ovaries removed? [ ] Yes [ ] No

Do you have any history of gestational diabetes? [ ] Yes [ ] No

High blood pressure or eclampsia with pregnancy? [ ] Yes [ ] No

Review of Current Problems:

Please check any current problems you have on the list below.

Please check those that apply:

[ ] Excessive thirst or urination

[ ] Snoring

[ ] Sleep apnea/CPAP

[ ] Difficulty hearing/ringing in your ears

[ ] Joint replacement (hip, knee, shoulder, etc.)

[ ] Back problems

[ ] Increased urination at night that interrupts Sleep

[ ] Bad breath

[ ] Anxiety

[ ] Unusual bleeding

Any other symptoms? If so, please list them: ____

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Family history- genetic lineage of family history can help determine risk and preventive alternatives.

Please indicate with a check mark any family members who have had any of the following medical conditions:

Medical condition	Mom	Dad	Sister	Brother	Daughter	Son	Mom's mom	Mom's dad	Dad's mom	Dad's Dad	Mom's sister	Mom's brother	Dad's sister	Dad's brother
Heart disease														
Stroke														
Diabetes-Type 2														
Anemia														
Aortic aneurysm														
Alzheimer's														
Arthritis														
Asthma														
Autoimmune disorder														
Bleeding problems														
Carotid artery disease														
Cancer														
Depression														
Diabetes-Type 1														
Other genetic disease														
High cholesterol														
High blood pressure														
Immunosuppressive disorders														
Kidney disease														
Osteoporosis														
Peripheral vascular														
Epilepsy														
Substance abuse														
Thyroid disorder														
Smoking														
Sleep apnea														
Polycystic ovary														
Coronary bypass														
Coronary stents														
Mini strokes														
Gum Disease														
Bad teeth														

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