adult registration & health history questionnaire

Please fill in your answers as thoroughly as possible. In our office we are interested in developing a complete dental health program for you. In order to do this we must know as much about the individual as we do about your teeth. No two people are the same; no two mouths are alike. All information, of course, will be held in strict confidence.

DATE ______________________

PATIENT'S NAME ______________________ DATE OF BIRTH ______________________

NAME (HUSBAND OR WIFE) ______________________

HOME ADDRESS ______________________

CITY ______________________ STATE ______________________ ZIP ______________________

CELL PHONE ______________________ WHAT IS YOUR OCCUPATION? ______________________

HOME PHONE ______________________ EMAIL ______________________

ARE YOU ASSOCIATED WITH A DENTAL INSURANCE PLAN? ______ NAME OF INSURANCE COMPANY ______________________

POLICY # ______________________

______________________ UNION (LOCAL #) ______________ UNION HEAD ______________________

NAME AND ADDRESS OF PERSON RESPONSIBLE FOR PAYMENT ______________________

____

FOR WHAT COMPANY DO YOU WORK? ______________________

BUSINESS PHONE ______________________ EXT. ______________________

IF MARRIED, OCCUPATION OF YOUR HUSBAND (OR WIFE) ______________________

FOR WHAT COMPANY DOES HE (SHE) WORK? ______________________

PHONE ______________________ EXT. ______________________

NUMBER OF CHILDREN IN FAMILY? __________ AGES ______________________

SOCIAL SECURITY NO. ______________________ DRIVER'S LIC. # ______________________

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ______________________

THANK YOU

Patterson #200066477

LAST NAME ______________ FIRST NAME ______________ DATE OF EXAM ______________

MEDICAL HEALTH HISTORY

General health (Please check):
☐ Excellent ☐ Good ☐ Fair ☐ Poor

If female: Are you pregnant? How long?

Who is your physician?

His address

When did you have your last complete physical examination?

Are you being treated for anything now? Recent Surgery? ________

Did you ever have (Please check):
☐ AIDS or HIV+ ☐ Tuberculosis
☐ Kidney Disease ☐ Liver Disease ☐ Asthma ☐ Diabetes
☐ Rheumatic Fever ☐ Anemia ☐ Epilepsy ☐ Heart Trouble
☐ Thyroid ☐ Hepatitis ☐ Venereal Disease ☐ Other ________

Is your blood pressure: ☐ high ☐ low ☐ normal

Blood pressure reading

Have you ever been treated with radiation?

Are you allergic to (Please check):
☐ Penicillin ☐ Codeine
☐ Novocaine ☐ Other

Are you taking Birth Control Pills? ________

Are you allergic to any other drugs? (Please specify)

Are you taking any medications now? If so, what? ________

Are you subject to prolonged bleeding?

Are you "high strung"?

Has your diet ever been evaluated?

Do you have trouble sleeping?

Do you have problems with digestion?

Do you smoke? ☐ yes ☐ no If yes, please specify: number of cigarettes per day ________ pipesfull ________ cigars ________

Signature ______________

DENTAL HEALTH HISTORY

Date of last dental exam

1. What concerns you most?
2. Do you have any pain in your teeth because of heat, cold or sweets? If so, where?
3. Do you have any pain in any part of the mouth or in any tooth while biting or chewing? If so, where?
4. Does food catch between your teeth? If so, where?
5. Do your gums bleed, either in chewing or brushing or at any other time? If so, when?
6. Do you clench your teeth during the day? Have you been made aware of clenching your teeth during the night?
7. Do you brush your teeth vigorously or lightly?

   How often do you brush your teeth?

   Do you avoid any part of the mouth while brushing?
8. Do your gums feel irritated, tender or swollen?
9. Are you completely happy with the appearance of your teeth?
10. Do you have all your teeth (other than wisdom teeth)?
11. If not, did you have missing teeth replaced?
12. Were you told why your missing teeth should be replaced?
13. Do you lose fillings or break silver fillings?
14. Do you feel that dentures are inevitable?
15. How often do you have calculus (tartar) removed? Every months.
16. Do you want to keep your own teeth as long as possible?