Elm Street FamilyDental Smile

REGISTRATION

PATIENT INFORMATION

Name _____ Today's Date _____
LAST FIRST MI

Male Female (please circle) Age _____ Birthdate _____ Soc. Security # _____

Home Phone No. _____ Minor Single Married Separated Widowed Divorced (please circle)

Cell Phone No. _____ email address: _____

Home Address _____
CITY STATE ZIP

Spouse/Parent Name _____ Spouse/Parent Soc. Security # _____

Other family members in this practice _____

whom may we thank for referring you? _____

Friend or Relative not living with you to notify in case of an emergency _____ Phone _____

EMPLOYMENT INFORMATION

Patient/Parent Employed By: _____ Occupation _____

Business Address _____ Business Phone _____ Ext _____

Spouse/Parent Employed By: _____ Occupation _____

Business Address _____ Business Phone _____ Ext _____

BILLING INFORMATION

Person Responsible for Account _____
LAST FIRST MI

Relation to Patient _____ Birthdate _____ Phone _____ Soc. Sec. # _____

Address (if different from patient's) _____
CITY STATE ZIP

PRIMARY INSURANCE INFORMATION

Insurance Co. Name _____ Insurance Co's Phone # _____

Insurance Co. Address _____
CITY STATE ZIP

Employer's Name _____ Subscriber's Name _____

Subscriber's Soc. Sec. # _____ Group # _____ Subscriber's Date of Birth _____

SECONDARY INSURANCE INFORMATION (if applicable)

Insurance Co. Name _____ Insurance Co's Phone # _____

Insurance Co. Address _____
CITY STATE ZIP

Employer's Name _____ Subscriber's Name _____

Subscriber's Soc. Sec. # _____ Group # _____ Subscriber's Date of Birth _____

RELEASE

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
- I authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
- I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____

HEALTH HISTORY

Answer all questions by circling Yes (Y) or No (N)

1. Are you in good health? ..... Y ☐ N ☐
2. Has there been any change in your general health in the past year? ..... Y ☐ N ☐
3. Date of last physical exam_____
4. Are you now under a physician's care for a particular problem? ..... Y ☐ N ☐
5. Have you ever had any serious illnesses, operations or hospitalizations? If so, describe ..... Y ☐ N ☐

   _____

   _____
6. Height_____ Weight_____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Any disease, drug or transplant operation that has depressed your immune system? ..... Y ☐ N ☐
   - B. Arthritis? ..... Y ☐ N ☐
   - C. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Y ☐ N ☐
   - D. Cancer, Chemotherapy, Port, Radiation (X-ray)? ..... Y ☐ N ☐
   - E. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur (Mitral Valve Prolapse, Rheumatic fever), Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpations, Heart Surgery, Pacemaker?) .... Y ☐ N ☐
   - F. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y ☐ N ☐
   - G. Congenital Heart Disease? ..... Y ☐ N ☐
   - H. Diabetes? ..... Y ☐ N ☐
   - I. Glaucoma? ..... Y ☐ N ☐
   - J. Implants or artificial joints placed anywhere in your body (Heart Valve,Pacemaker, Hip, Knee)? .... Y ☐ N ☐
   - K. Kidney Disease? ..... Y ☐ N ☐
   - L. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain? ..... Y ☐ N ☐
   - M. Obstructive Sleep Apnea, C-PAP ..... Y ☐ N ☐
   - N. Rheumatic Fever or Rheumatic Heart Disease? ..... Y ☐ N ☐
   - O. Seizures, Convulsions, Epilepsy, Fainting or Dizziness ..... Y ☐ N ☐
   - P. Sinus or Nasal problems? ..... Y ☐ N ☐
   - Q. Stomach Ulcers or Colitis? ..... Y ☐ N ☐
   - R. Thyroid Disease (Goiter)? ..... Y ☐ N ☐
   - S. Type of Cancer .....
8. **ARE YOU USING ANY OF THE FOLLOWING.**
   - A. Antibiotics? ..... Y ☐ N ☐
   - B. Anticoagulants (Blood Thinners)? ..... Y ☐ N ☐
   - C. Aspirin or drugs such as Aleve, Ibuprofen? ..... Y ☐ N ☐
   - D. High Blood Pressure medications? ..... Y ☐ N ☐
   - E. Steroids (Cortisone, Prednisone, etc.)? ..... Y ☐ N ☐
   - F. Tranquilizers? ..... Y ☐ N ☐
   - G. Insulin or Oral Anti-Diabetic drugs? ..... Y ☐ N ☐
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y ☐ N ☐
   - I. Have you ever taken a Bisphosphonate (Aredia, Zomex Actonel, Boniva, Fosamax, Skelid, Didronel)? ..... Y ☐ N ☐
   - J. Have you ever had a Bisphosphonate Reclast Injection? ..... Y ☐ N ☐
   - K. Please list all current medications taken, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:

     _____

     _____

     _____

     _____
9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocaine, etc.)? ..... Y ☐ N ☐
   - B. Penicillin or other antibiotics? ..... Y ☐ N ☐
   - C. Sedatives, Barbiturates, Sulfites? ..... Y ☐ N ☐
   - D. Aspirin or Ibuprofen? ..... Y ☐ N ☐
   - E. Codeine or other pain killers? ..... Y ☐ N ☐
   - F. Latex or Rubber Products? ..... Y ☐ N ☐
   - G. Eggs or Soybeans? ..... Y ☐ N ☐
   - H. Other allergies or reactions? Please, list

     _____

     _____

     _____
10. Do you smoke or chew Tobacco? ..... Y ☐ N ☐
    How much per day?_____
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect The care we provide you? ..... Y ☐ N ☐
12. Do you use recreational drugs? List ..... Y ☐ N ☐

    _____

    _____
13. Have you had any serious problems associated with any previous dental treatment? ..... Y ☐ N ☐
14. Have you or an immediate family member had any problem associated with anesthesia? ..... Y ☐ N ☐
15. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y ☐ N ☐
16. Do you wish to talk to the doctor privately about anything? ..... Y ☐ N ☐
17. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **is there any chance** you might be Pregnant? ..... Y ☐ N ☐
    - B. Are you nursing? ..... Y ☐ N ☐
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

I have read my health History dated_____and confirm that it adequately states past and present.

_____ _____

Date Signature of Person Completing Health History