

REGISTRATION AND HEALTH HISTORY

Name _____ Age _____ Sex M F

Home Address _____ City _____ State _____ ZIP _____

Date of Birth _____ Home Phone _____ Work Phone _____

Spouse's Name _____ Spouse's Date of Birth _____

How did you first become aware of our practice? (e.g. Internet, TV, John Doe, Yellow Pages) Please name: _____

E-Mail Address: _____ I would like to receive office and health information by e-mail: Y N

What prompted you to seek dental care at this time? (e.g. regular exam, pain, etc.) _____

Did you choose this practice primarily for the advanced CEREC 3D tooth colored restorations? Y N

Do you want the option of treatment planning the CEREC 3D, so that we can tell you more about it? Y N

How long since your last oral examination? _____

Have you had the Vizilite ® Oral Cancer test done in the last 5 years? Y N

Do you have a physician? Y N Name: _____ Location: _____

DO YOU HAVE OR IS THERE ANY PERSONAL HISTORY OF THE FOLLOWING? (Not a *family* history- **just you**)

Rheumatic Fever or Heart Disease?	Y	N	Pacemaker	Y	N
A Prosthesis such as:			Mitral Valve Prolapse:	Y	N
A heart valve	Y	N	with (please circle) Regurgitation	No regurgitation	Unknown
A knee or hip joint- give year _____	Y	N	High Blood Pressure	Y	N
Congenital Heart lesion or Murmur	Y	N	my last known BP was: _____ :		
Diabetes	Y	N	Arthritis	Y	N
Headaches on waking in the morning	Y	N	Asthma or Breathing Difficulty	Y	N
Grinding or clenching of the teeth	Y	N	Fainting Spells	Y	N
Psychiatric Treatment	Y	N	Seizures	Y	N
Frequent or very painful Cold Sores	Y	N	Ulcer	Y	N
Liver Disease or Chronic Hepatitis	Y	N	Abnormal Bleeding	Y	N
Kidney Disease, Dialysis or Transplant	Y	N	TB	Y	N
Immune System Disease, <i>AIDS</i> , or HIV Infection	Y	N	Cancer history:	Y	N
Are you Allergic to ANYTHING?	Y	N	If yes, list locations involved: _____		

Please list allergies: (e.g. penicillin, latex, etc.) _____

Are you *Currently Taking* any Medication or Pills ? **Y** **N** (please list below)

Do You Smoke ? **Y** **N** If yes, how many packs do you smoke/day ? _____ How many *years* have you done this ? _____
Chew or Dip ? **Y** **N** Use Alcohol Regularly ? **Y** **N**

Do you think your mouth is affecting your overall health in a negative way? **Y** **N**

Do you wish you could change the appearance of your smile? **Y** **N**

It is possible we can eliminate morning headaches and muscle soreness--
Are you interested in knowing more about this? **Y** **N**

It is possible we can help eliminate bad breath--
Are you interested in knowing more about this? **Y** **N**

Do your gums bleed easily, feel tender, or are irritated? **Y** **N**

In addition to a toothbrush, how often do you floss? Once every _____

Do you use a *Water Pik* ® ? **Y** **N**

Do you take any herbal supplements? **Y** **N** Please list _____

Has a fear of discomfort kept you from regular dental visits? **Y** **N**

Since there is no need to administer a “shot” anymore, is there anything else that makes you fearful that we can help you with?
For example, “I’d like to use the headphones to eliminate noise...or... I’d like to be sedated with nitrous oxide so I’m not so aware of my surroundings, etc.”

What would you say is/are the primary reasons you selected our office for care? circle up to 3

- | | | | |
|--------------------|--------------------------------|--------------|-------------------------------|
| High tech | CEREC 3D | Sterile | Pleasant surroundings / staff |
| Relaxing treatment | Computer controlled anesthesia | Laughing gas | Sterile |

WOMEN: Are you pregnant or breast feeding? **Y** **N**
Are you taking BC Pills? **Y** **N**
Are you taking calcium supplements? **Y** **N**

I have personally given the above information to the best of my knowledge, understanding that all medications / health information is confidential and necessary for the doctors to evaluate, diagnose and protect my health and well-being. I also understand that any changes / additions to this history are my responsibility to report some time prior to my next appointment.

Patient Signature _____ DATE _____

Reviewed by: _____