

# 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 search, TV, my friend "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 ® or VELscope ® Oral Cancer test completed 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**)

Heart Disease or Endocarditis (IE)	Y	N	Diabetes	Y	N
A Prosthesis such as:			Arthritis	Y	N
A heart valve or shunt	Y	N	Abnormal Bleeding	Y	N
A knee or hip joint- give year _____	Y	N	Fainting Spells or Seizures	Y	N
Congenital Heart lesion or Murmur	Y	N	Ulcer	Y	N
High Blood Pressure	Y	N	Psychiatric Treatment	Y	N
my last known BP was: _____ :			Canker Sores or Cold Sores	Y	N
Pacemaker	Y	N	Grinding or clenching of the teeth	Y	N
Asthma or Breathing Difficulty	Y	N	Headaches on waking in the morning	Y	N
Liver Disease or Chronic Hepatitis	Y	N	Cancer history:	Y	N
Kidney Disease, Dialysis or Transplant	Y	N	If yes, list locations involved: _____		
TB	Y	N	Allergy to metals	Y	N
Immune System Disease, AIDS, or HIV Infection	Y	N	Allergy to latex	Y	N

Please list all known allergies: \_\_\_\_\_

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

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Are you taking oral Bisphosphonates (Fosamax, Boniva, Actonel, Aredia, Zometa, etc)? **Y** **N**  
If so, for how many years? \_\_\_\_\_

Have you received any Bisphosphonates by IV? **Y** **N**

Do You Smoke ? **Y** **N** If yes, how many packs do you smoke/day ? \_\_\_\_\_ For how many years? \_\_\_\_\_  
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**

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.”

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Is there anything about your mouth/head/neck and/or your overall health that you have a question about? \_\_\_\_\_

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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: \_\_\_\_\_