REGISTRATION FORM/MEDICAL-DENTAL HISTORY

Patient's Name:____ Home #_________________
Work # _________________
Cell # __________________
Address ____ E-Mail _________________

City ______________________________________State _______________Zip Code ______________________

SS#______________________Date of Birth ____________________

Marital Status S M D W Spouse's Name:_______________________________

If minor, name of Parent or Guardian: ____

Address & Phone # ____
(If different from above)

Person responsible for fee (if other than patient) ____

Billing Address:____

Occupation of person responsible for bill/Name, address and **phone** # ___________________________

____Will you receive calls at work:__________________

Emergency Notification Nearest Relative not living with you. Name & Phone # ____________________

____.

Who can we thank for referring you:____

Permission to release Health Information

I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payors, and /or health practitioners.

Signature____Print Name__________________________________

DENTAL INSURANCE INFORMATION

Subscriber's Name ___________________________________Relation to Patient:______________________

Name of Insurance Co.__________________________________Phone #________________________________

Address of Insurance Co._________________________City_______________State________Zip___________

Group or Policy #_________________Subscriber's ID#__________________Date of Birth_______________

Subscriber's employer, address and phone #____

INSTRUCTIONS

To receive treatment you must answer all questions on this history form. The questions asked relate directly to the safe and effective treatment you are to receive in the office—to the best of your ability honest answers must be given. If you are unsure of the questions, your answer, or whether the questions relates to your medical condition, you are to discuss the matter with the doctor.

Some questions may not relate to you or your medical condition; in that event you are to write "N/A" (not applicable in the space provided).

ALL INFORMATION YOU SUPPLY TO THE OFFICE ON THIS FORM, AND THE SUBSEQUENT INTERVIEW BY THE DENTIST AND RECEIVED FROM YOUR PHYSICIAN OR ANY OTHER SOURCE WILL BE HELD IN THE STRICTEST CONFIDENCE, AND WILL NOT BE DISCLOSED WITHOUT YOUR EXPRESS AND WRITTEN PERMISSION.

1. Name and phone # of physician:____

2. Date of last visit to your doctor ____________________Purpose of visit_________________________

3. Have you ever, or do you now take illegal drugs? _______If yes, what drugs, and when take?_____

____Note: There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal.

4. Do you have AIDS, or are you HIV -positive? YES NO If yes describe and provide current

status.____

5. Have you ever had, or do you now have any sexually-transmitted disease? YES NO If yes,

describe.____.

6. Have you ever had, or do you now have Hepatitis/Jaundice YES NO If yes

describe:____

7. Have you ever taken Phen Fen, Pondimin or Redux? YES NO

8. Have you ever had an Allergic Reaction to medication, metals, food, or latex? YES NO If yes

describe:____

9. Are you taking any drugs or medications YES NO If yes, list and describe amounts and

purpose:____

10. Have you lost weight recently? YES NO If yes, describe:_____________________________

11. **FOR FEMALES:** Are you pregnant? YES NO If yes, how many months or when are you due?______

12. **FOR FEMALES:** Are you taking birth control pills? YES NO (Note: There are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills.)

HAVE YOU EVER HAD OR BEEN TREATED FOR:

1. Stomach or intestinal disease? ____.
2. Prolonged or excessive bleeding, or anemia? ____________________________
3. Joint replacement, what and when?____.
4. Have you ever had a major operation? If yes, describe and year? ________________________.

   ____.
5. Have you ever had a sports or other injury to your head or neck? If yes, describe and year?____________.

   ____.
6. Surgery/Scars: ____
7. Are there any other problems about your health of which you are aware?__________________________.
8. Do you or have you ever used tobacco products? If yes, list the type:____________Amount use per day:

   ____.
9. Do you have or ever had gerd, acid reflux, indigestion, heartburn? If so, what was/has been done? ___

   ____.
10. Have you or do you experience any gas, bloating, constipation? ____________________________________

    ____
11. Have you consulted or been treated by a psychiatrist, psychologist, or counselor? If yes, describe:______.

    ____.

DENTAL HISTORY

1.. May we call for your dental records and x-rays? YES NO Name and phone # of Dental Office____ ___.

____.

In respect to any previous dental treatment have you:

2. Had an allergic reaction to anesthetic? YES NO If yes, describe__________________________________.
3. Had abnormal bleeding? YES NO If yes, describe:____.
4. Any other complications during or following dental treatment? YES NO IF yes, describe___________.

   ____.

5. Describe your current health concerns (include onset, duration, frequency, severity, changes, etc.) ______

____.

7. Dental History:

Silver fillings	_____	TMJ	_____	Implants	_____
Root Canal	_____	Periodontal Disease	_____	Bridge	_____
Gum Problem	_____	Dentures	_____	Others	_____
Bad Breath	_____				

8. INDICATOR CHECK LIST

	Yes	No			
Cold hands and/or feet	Y	N	Loose, frequent, watery stools	Y	N
Cold intolerance	Y	N	Gas	Y	N
Dry Skin	Y	N	Mood swings	Y	N
Dizziness after standing quickly	Y	N	Ringing in the ears	Y	N
Brittle/dull/dry hair	Y	N	Eczema	Y	N
Sleep disturbances	Y	N	Fluid retention	Y	N
Grogginess upon waking	Y	N	Low or absent sweating	Y	N
Difficulty relaxing	Y	N	Bruise easily	Y	N
Poor concentration/memory	Y	N	Muscle tightness &/or inflexibility	Y	N
Frequent urination	Y	N	Joint stiffness/aching/swelling	Y	N
Brittle/peeling fingernails	Y	N	Glasses for distance/reading	Y	N

9. Diet: Check if applicable:

Crave certain foods	_____	Eat daytime snacks	_____
Avoid certain foods	_____	Eat bedtime snack	_____
Skip meals	_____	Rotation diet(s)	_____
Use "fast" foods	_____	Over indulge food(s)	_____
Elimination diet(s)	_____	Reaction to foods	_____
Caveman/Atkins diet	_____	Candida diet	_____
Cook from scratch	_____	Macrobiotic diet	_____
Vegetarian diet	_____	Low fat diet	_____
Mediterranean diet	_____	Paleo diet	_____

10. Other – List any concerns not mentioned in any question above: (e.g., problems with vaccination/travel related illness/etc.) ____

____

11. List your current activities/exercise (specify frequency, duration, and time(s) of day): ______________

____

12. Drops in energy: Y N If yes, at what time(s) of day______________________________

13. How many glasses of water do you regularly drink on a daily basis? ________

14. List all supplements you currently take:____

____

15. What are your goals? ____

16. Any other comments?____

____

17. Do any essential oils, fragrances, or smells bother you? Which ones? ______________________

____

18. Please list all essential oils you currently use or have used? ___________________________

____

19. List ALL the foods/fluids/beverages you eat & drink each day, including the time of day and average amounts:

Time	Foods	Fluids/Beverages
________ Breakfast		
________ Lunch		
________ Dinner		
________ Snacks		

NOTE: A change in your health status should be reported to the office at the earliest possible time:

To the best of my knowledge, the foregoing questions have been accurately answered.

Signature________________________________Print Name____________________________________.

Date________________________If other than patient, indicate relationship______________________.

Dental Practice Witness:________________________________