

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 _____

HOME PHONE _____ WHAT IS YOUR OCCUPATION? _____

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

POLICY NUMBER _____

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. _____ DRIVERS LIC. # _____

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

THANK YOU

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?

Physician's 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 / 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 Are you taking _____

Novocaine Other Birth Control Pills? _____

Are you allergic to any other drugs? Are you taking any medications now?

(Please Specify) 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 _____ Pipes/roll _____ 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?