

# REGISTRATION AND HEALTH HISTORY

Name		Single	Married	Long-Term Partner	Divorced	Separated	Widowed
Social Security number		Birthdate		Home phone		Business phone	
Address			City		State	Zip	
Employed by			City		State	Zip	
Present position		How long held		Your driver license no.			State
Spouse/partner's name							
Spouse/partner's Social Security number				Spouse/partner's birthdate		Business phone	
Spouse/partner employed by			City		State	Zip	
Present position		How long held		Spouse/partner's driver license no.			State
Referred by				Address			
Who will pay for this account?			Credit card name		No.	Expiration date	
Name of your dental insurance company							
Name of your spouse/partner's dental insurance company							

*It is important that I know about your dental and medical history. Many things have a direct bearing on your dental health. I will review the questionnaire and discuss it with you in detail. Information you give me is strictly confidential and will not be released to anyone without your written permission.*

## YOUR DENTAL HISTORY

**Are** you having any discomfort at this time \_\_\_\_\_ **How** long since you have been to a dentist \_\_\_\_\_

**Did** you have X-Rays \_\_\_\_\_ **How** often did you visit a dentist before then \_\_\_\_\_ **Have** you lost any teeth \_\_\_\_\_ **Why** \_\_\_\_\_

**Any** complications with extractions \_\_\_\_\_

**Have** they ever been replaced by: (1) A Fixed Bridge \_\_\_\_\_ (2) Removable Partial \_\_\_\_\_ (3) Denture \_\_\_\_\_

How many of (1) (2) (3) \_\_\_\_\_

**Are** your teeth sensitive to heat \_\_\_\_\_ to cold \_\_\_\_\_ to sweets \_\_\_\_\_ to sour \_\_\_\_\_ **Have** you had your teeth straightened \_\_\_\_\_

When \_\_\_\_\_ **How** often do you brush your teeth \_\_\_\_\_ When \_\_\_\_\_

**How** \_\_\_\_\_

**How** long do you use a toothbrush before replacing it \_\_\_\_\_

**Do** you use dental floss \_\_\_\_\_ **How** often \_\_\_\_\_

Between-the-teeth stimulator \_\_\_\_\_ Water jet \_\_\_\_\_

**Do** you have bleeding gums \_\_\_\_\_ **When** \_\_\_\_\_

**Do** you eat between meals \_\_\_\_\_ **Do** you brush teeth after snacks \_\_\_\_\_ **Does** food wedge between your teeth \_\_\_\_\_

Where \_\_\_\_\_ **Do** you grind or clench your teeth \_\_\_\_\_ **When** \_\_\_\_\_

**Have** you ever had gum treatments \_\_\_\_\_ **When** \_\_\_\_\_

**Do** you feel you have bad breath at times \_\_\_\_\_

**Unpleasant** taste in mouth \_\_\_\_\_ **Any** pain in or around your ears \_\_\_\_\_ **Do** you hear popping, clicking or snapping noises when you chew \_\_\_\_\_ **Do** you have any nasal obstruction \_\_\_\_\_ **Are** you aware of any swelling or lump in your mouth \_\_\_\_\_

*Other side, please.*

Do you now have or have you had any of the following habits: Thumbsucking \_\_\_\_\_ Fingersucking \_\_\_\_\_

Cheek or tongue chewing \_\_\_\_\_ Chewing on Pencils \_\_\_\_\_ Pens \_\_\_\_\_ Lips \_\_\_\_\_ Fingernails \_\_\_\_\_

Tobacco use \_\_\_\_\_ Alcohol use \_\_\_\_\_

Do you have any fear of having dentistry done \_\_\_\_\_

If yes, why \_\_\_\_\_

How do you feel about your teeth \_\_\_\_\_

How do you feel about dentures \_\_\_\_\_

Do you want to avoid the dental discomfort you may have experienced in the past \_\_\_\_\_

Do you want to avoid dentures \_\_\_\_\_

Do you want to have a pleasant breath \_\_\_\_\_

Do you want to know how you can keep the natural teeth you still have \_\_\_\_\_

If you have children, do you want to learn how they may keep their natural teeth for a lifetime without discomfort \_\_\_\_\_

### MEDICAL HISTORY

Physician's name \_\_\_\_\_ Date of last physical exam \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Do you have or have you had any of the following. Please indicate with check mark (✓).

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Any heart problems       | <input type="checkbox"/> Allergies to medicines or drugs | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Sinus Problems   |
| <input type="checkbox"/> High blood pressure      | <input type="checkbox"/> Allergies to: _____             | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Low blood pressure       | _____  | <input type="checkbox"/> Herpes           | <input type="checkbox"/> Typhoid Fever    |
| <input type="checkbox"/> Circulatory problems     | _____  | <input type="checkbox"/> Malignancies     | <input type="checkbox"/> Tonsillitis      |
| <input type="checkbox"/> Nervous problems         | _____  | <input type="checkbox"/> Measles          | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Radiation treatments     | <input type="checkbox"/> Anemia                          | <input type="checkbox"/> Mumps            | <input type="checkbox"/> Ulcer            |
| <input type="checkbox"/> Excessive bleeding       | <input type="checkbox"/> Arthritis                       | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> HIV/AIDS                 | <input type="checkbox"/> Asthma                          | <input type="checkbox"/> Rheumatic Fever  | <input type="checkbox"/> Other            |
| <input type="checkbox"/> Allergies to anesthetics |  | <input type="checkbox"/> Scarlet Fever    |   |

Are you pregnant \_\_\_\_\_ Blood Pressure: S \_\_\_ /D \_\_\_ / \_\_\_

**Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment.**

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_ Your signature \_\_\_\_\_