Patient Registration & Health History

Please complete the following confidential information

1. If this appointment is for you, start here

Date _____

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone No. _____

Date of Birth _____ Age _____

Are you: ❒ Married ❒ Single ❒ Divorced ❒ Widowed

Patient's Social Security Number _____

Occupation _____

Employer _____

Business Address _____ City _____

Business Phone No. _____ ext. _____

YOUR SPOUSE

Name _____

Spouse's Employer _____

Business Address _____ City _____

Business Phone No. _____ ext. _____

If this appointment is for your child, start here

Date _____

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone No. _____

Date of Birth _____ Age _____ Grade _____

School _____

If your child's name and address are not the same as yours,
please complete the above information in addition to your own.

2. Dental Insurance

Primary Carrier

Insurance Company _____

Employee _____

Union or Local No. _____

Group No. _____

Employee Badge No. _____

Date Employed _____

Employee Social Security No. _____

Secondary Carrier

Insurance Company _____

Employee _____

Union or Local No. _____

Group No. _____

Employee Badge No. _____

Date Employed _____

Employee Social Security No. _____

Patient Registration & Health History

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3. Getting to Know You

Is another member of your family, or relative a patient at our office? _____

Their name _____

Referred to us by _____

4. Account Information

Person financially responsible for account. ❒ Check here if same as #1 above.

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone No. _____

Business Phone No. _____ ext. _____

	Circle	
1. Are you having pain or discomfort at this time?	Yes	No
2. Do you feel very nervous about having dental treatment?	Yes	No
3. Have you ever had a bad experience in the dental office?	Yes	No
4. Have you been a patient in the hospital during the past two years?	Yes	No
5. Have you been under the care of a medical doctor during the past two years?	Yes	No

Your Physician's name _____

Address _____ Phone No. _____

Date of your last complete medical physical? _____

6. Have you taken any medicine or drugs during the past two years?	Yes	No
Are you now taking medication, drugs or pills?	Yes	No

If so, please list: _____

7. Are you allergic or have you reacted adversely to any of the following medications?	Yes	No

If yes, please circle.

Aspirin	Nitrous Oxide	Valium	Local Anesthetic
Darvon	Erythromycin	Scopolamine	Novocain or Xylocaine
Codeine	Tetracycline	Penicillin	Sleeping pills
Demerol	Percodan	Other Antibiotics	Nembutal/Seconal

8. Are you aware of being allergic to any other medications or substance?	Yes	No

If yes, please list: _____

9. Circle any of the following which you have had or have at present:

Heart failure	Stroke	Rheumatism	Anemia
Heart disease or attack	Emphysema	AIDS	Nervousness
Angina Pectoris	Cough	Hepatitis A (infectious)	Kidney trouble
High blood pressure	Tuberculosis (TB)	Hepatitis B (serum)	Ulcers
Heart Murmur	Asthma	Liver disease	Cosmetic surgery
Rheumatic fever	Hay Fever	Yellow jaundice	Glaucoma
Congenital Heart Lesions	Sinus trouble	Blood transfusion	Pain in jaw joints
Psychiatric treatment	Allergies or hives	Drug addiction	Scarlet fever
Artificial Heart Valve	Diabetes	Hemophilia	Sickle cell disease
Heart pacemaker	Thyroid disease	Venereal disease	Bruise easily
Heart surgery	Cold sores	Chemotherapy	Fever blisters
Fainting or dizzy spells	Arthritis	Epilepsy or seizures	
X-ray or Cobalt treatment	Artificial joints (hip, knee)		

Patient Registration & Health History

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10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest?	Yes	No
11. Do your ankles swell during the day?	Yes	No
12. Do you use more than two pillows to sleep?	Yes	No
13. Have you lost or gained more than 10 pounds in the past year?	Yes	No
14. Do you ever wake up from sleep short of breath?	Yes	No
15. Are you on a special diet?	Yes	No
16. Has your medical doctor ever said you have cancer or a tumor?	Yes	No
17. Do you have any disease, condition or problem not listed?	Yes	No

FOR WOMEN ONLY

Are you pregnant?	Yes	No
If yes, what month? _____		
Are you taking birth control pills?	Yes	No

I confirm the above information is true.

Patient Signature _____ Date _____

Consent:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Patient name) _____and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made.

Patient Signature _____ Date _____

Parent/responsible party _____ Relationship to patient _____

Witness _____ Date _____

Personal Planning Profile

What are the patient's...

Objectives _____

Desires (Hopes & Dreams) _____

Concerns/Problems _____

Barriers _____

Personal Comments:

Clinical Photography

Images to be Taken:

Continuum Level 1

Full face - frontal (1 image)
Profile left and right views (2 images)
Lips at rest position (1 image)
Smile (1 image)
Lateral smile right and left views (2 images)
Anterior close-up in maximum intercuspation (1 image)
Close-up of maxillary anteriors (1 image)
Frontal full arch in maximum intercuspation (1 image)
Frontal full arch in centric relation (1 image)
Maxillary anterior (palatal) (1 image)
Mandibular anterior (lingual) (1 image)

Continuum Level 2

Maxillary occlusal full arch (1 image)
Mandibular occlusal full arch (1 image)

Continuum Level 2E

Buccal occluded left and right views (2 images)
Mandibular lingual right and left views (2 images)
Maxillary palatal left and right views (2 images)

Continuum Level 3

Review slides from home

Continuum Level 4

Review documented case from home

Continuum Level 5

Present a documented case from home to your classmates

Continuum Level 6

Present a case