HEALTH HISTORY & REGISTRATION

CHART # _____

Patient's Name (Last)_____(First)_____ (MI)_____ **DOB**_____/_____/_____
Who May We Thank for Referring You to our Office?_____
Reason for this visit_____

RESPONSIBLE PARTY INFORMATION (Patient Listed above, or Parent / Guardian's info)

Name (Last) _____ (First)_____ (MI)_____
Address _____ Apt#_____
City _____ State_____ Zip_____

Employer _____
Work Address _____ City _____ State _____ Zip Code_____

Home Phone ( )_____-_____ Cell Phone ( )_____-_____ Work ( ) _____-_____
Emergency Contact: _____ Phone ( ) _____-_____
Remind me of appointments via Text: **Yes**/**No**? Cell phone service provider_____ (needed to send texts)
Remind me of appointments via E-mail: **Yes**/**No**? E-mail _____ (needed to send E-mails)

MEDICAL HISTORY OF THE PATIENT

(Please fill out everything below)

Rate your smile: Not Satisfied 1 2 3 4 5 6 7 8 9 10 Very Satisfied — What would your change about your smile: _____
How important is it to keep your teeth for the rest of your life? Not important 1 2 3 4 5 6 7 8 9 10 Very Important
Are you pregnant? **Yes / No** — If yes, how many mo:_____
Do you have any current health problems? **Yes / No** — If yes, please explain: _____
Are you under a physician's care now? **Yes / No** — If yes, please explain: _____
Do you chew tobacco or smoke? **Yes / No** — If yes, please explain: _____

What medications are you taking? **None / List**: _____

_____

Are you allergic to or have you reacted adversely to any of the following medications? **Yes / No** If yes, please circle below.

Local Anesthetic	Penicillin	Erythromycin	Codeine	Nitrous Oxide
Latex	Aspirin	Ibuprofen	Sulfa Drugs	Nickel or Other Metal: _____

Are you allergic to or have you reacted adversely to any other medication, material, foods, etc...? **Yes / No** List: _____

_____

Have you or your family member been diagnosed with Methemoglobinemia? **Yes / No** — If yes, when:_____
Are you taking daily Aspirin, Warfarin, or any Blood Thinner medication? **Yes / No** — If yes, when:_____
Have you ever taken (circle) Fen-Phen / Redux? **Yes / No** — If yes, when:_____
Have you ever had Heart Surgery or Prosthetic Heart Valve? **Yes / No** — If yes, when:_____
Have your ever had a Heart Attack, Chest Pain, or Heart Problem? **Yes / No** — If yes, when:_____
Have you had surgery for any Prosthetic/Artificial Joints? **Yes / No** — If yes, when: _____
Have you taken Bisphosphonates (Drugs for Osteoporosis (circle): Fosamax, Actonel, or Boniva)? **Yes / No** Other medication: _____
Have you ever had Radiation treatment? **Yes / No** If yes, where/when?_____
Have you ever had medication or chemotherapy for the treatment of Cancer or Tumor? **Yes / No** If yes, where/when?_____

Please √ Yes or No for the Following listed below:

	Yes	No		Yes	No		Yes	No
AIDS/HIV	☐	☐	Fainting	☐	☐	Pace Maker	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Psychiatric Care	☐	☐
Angina (Heart Pain)	☐	☐	Heart Murmur	☐	☐	Rheumatic/Scarlet Fever	☐	☐
Arthritis	☐	☐	Hepatitis	☐	☐	Sinus Trouble	☐	☐
Asthma	☐	☐	High Blood Pressure	☐	☐	Stroke	☐	☐
Bleeding Problems	☐	☐	Jaundice	☐	☐	Thyroid Problem	☐	☐
Cosmetic Surgery	☐	☐	Kidney Problems	☐	☐	TMD/TMJ	☐	☐
Diabetes	☐	☐	Liver Problems	☐	☐	Tuberculosis	☐	☐
Dizzy Spells	☐	☐	Low Blood Pressure	☐	☐	Venereal Disease	☐	☐
Drug Addiction	☐	☐	Lung Disease	☐	☐	Methemoglobinemia	☐	☐
Epilepsy	☐	☐	Mitral Valve Prolapse	☐	☐			

Patient Signature (Parent of Child) _____Date _____ Dentist Signature _____

Medical Update (please make any changes directly on this form, then sign and date below:
Patient Signature (Parent of Child) _____Date _____ Dentist Signature _____
Patient Signature (Parent of Child) _____Date _____ Dentist Signature _____