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.

By working together, we can strive to keep your natural teeth and thus improve your enjoyment of food, your appearance, your comfort and your health for the rest of your life.

DATE _____

PATIENT'S NAME _____ DATE OF BIRTH _____

SOCIAL SECURITY NO. _____ EMAIL _____

NAME (SPOUSE) _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ BUSINESS PHONE _____ EXT. _____ CELL PHONE _____

FOR WHAT COMPANY DO YOU WORK? _____

ARE YOU ASSOCIATED WITH A DENTAL INSURANCE PLAN? _____

NAME OF INSURANCE COMPANY _____

IF MARRIED, OCCUPATION OF YOUR SPOUSE _____

_____

FOR WHAT COMPANY DOES HE (SHE) WORK? _____

PHONE _____ EXT. _____ CELL PHONE _____

NAME AND ADDRESS OF PERSON RESPONSIBLE FOR PAYMENT _____

_____

NUMBER OF CHILDREN IN FAMILY _____ FIRST NAME & AGES _____

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?

Do you or did you ever have:

☐ High Cholesterol	☐ AIDS or HIV +	☐ Tuberculosis	
☐ Kidney Disease	☐ Liver Disease	☐ Asthma	☐ Diabetes
☐ Rheumatic Fever	☐ Anemia	☐ Epilepsy/Convulsions	☐ 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	☐ Other
☐ Novocaine	☐ Latex	Are you taking Birth Control Pills?_____

Are you allergic to any other drugs? (Please specify)

Are you taking any medications now?
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 or chew tobacco? ☐ yes ☐ no If yes, please specify number of:

cigarettes per day ____ pipefulls per day____ cigars per day____ chews per day____

Signature _____

DENTAL HEALTH HISTORY

Date of last dental exam _____

1. What concerns you most about your dental health?
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?