

**PATIENT REGISTRATION
& HEALTH HISTORY**

DENTISTRY
Of
Olde Towne

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Patient Name: _____ Birthdate: _____ Age: _____

Address: _____
Street (No P.O. Box numbers, please) City State Zip

Patient Social Security #: _____ Email address for contact: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer Name and Address: _____

Referred By: _____

Former Dentist: _____ Address: _____
City State

Physician: _____ Address: _____
City State

Name of Parent/Spouse: _____ Birthdate: _____ Social Security #: _____

Parent/Spouse Address: _____
(If different from patient) Street City State Zip

- | <u>No</u> | <u>Yes</u> | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you in good health? Date of last physical exam? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you currently taking any medicine or drugs? If yes, list _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any allergies to medicine, drugs, food (i.e. penicillin, aspirin)? If yes, list _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you experienced any unfavorable reaction to any previous dental treatment? If yes, list _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Women: Are you pregnant, is there any chance you are pregnant, or are you planning a pregnancy? |

Do you have, or have you had any of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Emphysema, COPD | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Anemia | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Blood Pressure Problems | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Diabetes (Type 1 or 2) | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hepatitis (A, B, C) |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Liver Disease, Jaundice |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Immune Deficiency | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cancer |

Do you have health problems other than those listed above? If so, please list _____

What is your present dental problem? _____ Date of last dental visit: _____

If you could rate your smile from 1 to 10, with 10 being the best, what rating would you give yourself? _____

Would you want to do anything to improve your smile? _____

Do you have anxiety regarding dental treatment? (circle one) none mild moderate severe

IF YOU HAVE DENTAL INSURANCE WE WILL ESTIMATE YOUR PORTION TO BE PAID AT THE TIME PROFESSIONAL SERVICES ARE RENDERED. IF THERE IS NO INSURANCE COVERAGE FOR YOUR TREATMENT, PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE AND I AGREE TO THE PAYMENT TERMS.

Date: _____ Signature: _____