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

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Have they ever been replaced by: (1) A Fixed Bridge _____ (2) Removable Partial _____ (3) Denture _____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 _____ Lip _____ 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 your 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 (✔)

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

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.

_____

_____

_____

_____

_____

_____

_____

_____

Date _____ Your signature _____