

Registration and Health History

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.

Name _____
 Single ___ Married ___ Divorced ___ Separated ___ Widowed ___
 Social Security Number _____ - ___ - ___ Birthdate _____
 Home phone _____ Business phone _____
 Residence Address _____
 City _____ State _____ Zip _____
 Employed by _____
 City _____ State _____ Zip _____
 Name of relative not living with you _____
 Address _____ Phone _____
 Referred by _____
 Who will pay for this account? _____
 Name of your Dental Insurance Co _____
 Address _____

City _____ State _____ Zip _____
 Group # _____ Policy# _____
 Spouse name (or parent's info if patient is a child) _____
 Spouse's SS# ___ - ___ - ___ Spouse birthdate _____
 Business phone _____
 Spouse employed by: _____
 City _____ State _____ Zip _____
 Present position _____
 Name of your spouse's insurance company _____
 Address _____
 City _____ State _____ Zip _____

YOUR DENTAL HISTORY

Which of the following applies to you? Please indicate with a check mark.

<input type="checkbox"/> Discomfort at this time	<input type="checkbox"/> Use dental floss How often _____	<input type="checkbox"/> Are you pleased with the appearance of your teeth? _____
<input type="checkbox"/> Heat sensitivity	<input type="checkbox"/> Use water jet	<input type="checkbox"/> Are there spaces between your teeth that you dislike? _____
<input type="checkbox"/> Cold sensitivity	<input type="checkbox"/> Food wedges between teeth Where _____	<input type="checkbox"/> Are you satisfied with the color of your teeth? _____
<input type="checkbox"/> Biting sensitivity	<input type="checkbox"/> Eat between meals	<input type="checkbox"/> Are you satisfied with the shape of your teeth? _____
<input type="checkbox"/> Sweet sensitivity	<input type="checkbox"/> Brush after snacks	<input type="checkbox"/> Are any of your teeth chipped? _____
<input type="checkbox"/> Grind or clench teeth	<input type="checkbox"/> Complications with extractions	<input type="checkbox"/> How often do you brush your teeth _____
<input type="checkbox"/> Popping or clicking when chewing	<input type="checkbox"/> Bad breath	<input type="checkbox"/> How long do you use a toothbrush before replacing? _____
<input type="checkbox"/> Pain in or around ears	<input type="checkbox"/> Unpleasant taste in mouth	<input type="checkbox"/> Nasal obstruction
<input type="checkbox"/> Teeth straightened	<input type="checkbox"/> Chew tobacco	<input type="checkbox"/> Gum treatments When? _____
<input type="checkbox"/> Smoke	<input type="checkbox"/> Bleeding gums	

Your Medical History

Physician's name _____ Date of last physical exam _____

List ALL medications you are currently taking, dosages, and reasons for taking them

MED NAME	DOSAGE	REASON	MED NAME	DOSAGE	REASON
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Do you have or have you had any of the following. Please indicate with a check mark.

<input type="checkbox"/> Any heart problems	<input type="checkbox"/> Allergies to anesthetics	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Herpes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Joint replacements
<input type="checkbox"/> Malignancies	<input type="checkbox"/> Typhoid fever	<input type="checkbox"/> Measles	<input type="checkbox"/> Circulatory problems	<input type="checkbox"/> Heart valve problem
<input type="checkbox"/> Tonsilitis	<input type="checkbox"/> Nervous problems	<input type="checkbox"/> Mumps	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Radiation treatments	<input type="checkbox"/> Sexually transmitted disease	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Psychiatric care	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Excessive bleeding	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> AIDS/HIV

Other _____

List all allergies to medications _____

Women: Are you pregnant? _____ Are you taking oral contraceptives? _____ (Antibiotics can render oral contraceptives ineffective)

Please describe any current medical treatment, impending operations, or any other medical or dental information.

DA or RDH _____

AUTHORIZATION: (please read the following information carefully) I grant authority to the Dentist to perform procedures and treatments, including administration of medicine, local and general anesthetics, and extractions along with other surgical and dental procedures that may be necessary. I/we agree to pay a finance charge of 1.5% per month (an annual rate of 18%) on the unpaid balance after 90 days and up to 100% of collection costs and/or a reasonable attorney's fee if any delinquent balance is placed with an agency or attorney for collection or suit. I/we hereby authorize release of any information relating to dental treatment and dental claims. I/we agree to be responsible for payment of services not covered by insurance. I hereby authorize payment of all dental insurance benefits directly to: D. Kent Godfrey (Dentist)

AUTHORIZED SIGNATURE: _____ DATE: _____