HEALTH HISTORY & REGISTRATION

Today's Date _____

Patient's Name _____ Sex: M F Birthdate _____ Age _____

Home Address _____ City _____ State _____ Zip _____

Please circle one: Single Married Separated Divorced Widowed Home Phone No. _____ Occupation _____

Your employer _____ Soc. Sec. No. _____ Work Phone No. _____

E-Mail Address: _____ Cell Phone No.: _____

Are you a full time student? ☐ Yes ☐ No If patient is a minor we need Mother's B/D _____ Father's B/D _____

Name of Spouse (Parent if minor) _____ Person responsible for account _____

Spouse/Parent's Employer _____ Spouse/Parent's Soc. Sec. No. _____

Work Phone No. _____ Emergency Information: _____

Referred to us by _____ Name, Address & Telephone of a Relative or Friend NOT living with you

_____ _____

_____ _____

DENTAL INSURANCE INFORMATION (Primary Care)

Insured's Name _____
Insurance Co. _____
Insurance Co. Address _____
Insured's Employer _____
Insured's Soc. Sec. # _____
Group # _____ Local # _____

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name _____
Insurance Co. _____
Insurance Co. Address _____
Insured's Employer _____
Insured's Soc. Sec. # _____
Group # _____ Local # _____

It is important that we know your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

MEDICAL HISTORY

	Yes	No
Do you have any current health problems _____	☐	☐
Are you under a Physician's Care now? _____	☐	☐
If yes, for what? _____		
Are you currently taking any medication? _____	☐	☐
If yes what? _____		
Pharmacy Name: _____ Phone: _____		
Height: _____ Weight: _____		
Are you pregnant? _____ Due Date _____	☐	☐
Do you smoke? _____	☐	☐

General Health: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Name address and phone number of your physician:

_____

_____

Last complete physical? _____

Have you been hospitalized in the past 5 years? _____ ☐ ☐

If yes, give reason and date _____

_____

Circle any of the following which you had or have at the present:

Heart Failure	AIDS/HIV
Leaky Heart Valve	Heart Disease or Attack
Angina Pectoris	Hepatitis A (infectious)
Mitro Valve Prolapse	Hepatitis B (serum)
Pains in Chest	Hepatitis C
Bruise Easily	High Blood Pressure
Liver Disease	Emphysema
Heart Murmur	Shortness of Breath
Tuberculosis (TB)	Rheumatic Fever
Blood Transfusion	Asthma
Congenital Heart Lesions	Hay Fever
Hemophilia	Sinus Trouble
Artificial Heart Valve	Fever Blisters
Allergies or Hives	Pacemaker
Epilepsy or Seizures	Diabetes
Heart Surgery	Fainting or Dizzy Spells
Thyroid Disease	Artificial Joints (Hip, Knee)
Nervousness	Anemia
Psychiatric Treatment	Arthritis
Stroke	Sickle Cell Disease
Rheumatism	Kidney Trouble
Glaucoma	Cortisone Medicine
Ulcers	Chemotherapy (Cancer, Leukemia, Radiation)
Pain in Jaw Joints	
Cosmetic Surgery	Alcoholism
Drug Addiction	Bleeding Problems

Are you allergic to or have you reacted adversely to any of the following medications? Aspirin Percodan Local Anesthetic Codeine Erythromycin Sulfur Penicillin Other _____

CONSENT:

The undersigned hereby authorizes any member of the staff of the office of Mercerville Family Dental to take x-rays, study models. photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge may be added to any overdue balance. I also assign all Insurance benefits to the Doctor.

PATIENT Signature (Parent or Child) Date: _____

DENTIST Signature: _____