Patient Number ______ A B C

# HEALTH HISTORY & REGISTRATION

## PATIENT INFORMATION

PATIENT'S NAME Last ______ First ______ Middle Initial ______ SEX: M F BIRTHDATE ______ AGE ______

Soc. Sec. No. ______ If Patient is a Minor, give Parent's or Guardian's Name ______ TODAY'S DATE ______

Who May We Thank for Referring You to our Office? ______ Reason for Visit ______

## RESPONSIBLE PARTY INFORMATION

NAME Last ______ First ______ Middle ______ MARITAL STATUS ______

RESIDENCE Street ______ City ______ State ______ Zip ______

MAILING ADDRESS Street ______ City ______ State ______ Zip ______

HOW LONG AT THIS ADDRESS? ______ Cell ______ HOME PHONE ______ WORK PHONE ______

EMAIL ______

SOCIAL SECURITY NO. ______ BIRTHDATE ______ DRIVER'S LICENSE NO. ______ RELATION TO PATIENT ______

EMPLOYER ______ OCCUPATION ______ NO. YEARS EMPLOYED ______

## RESPONSIBLE PARTY'S SPOUSE

NAME ______ (LAST) (FIRST) (MIDDLE)

EMPLOYER ______ NO. YEARS EMPLOYED ______

OCCUPATION ______ SOC. SEC. NO. ______

WORK PHONE ______ BIRTHDATE ______

## EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU

NAME ______

ADDRESS ______

CITY, STATE ______ PHONE ______

## DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name ______

Insurance Co. ______

Insurance Co. Address ______

Insured's Emplnyer ______

Insured's Soc. Sec. No. ______ Group No. ______ Local No. ______

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

Insured's Name ______

Insurance Co. ______

Insurance Co. Address ______

Insured's Employer ______

Insured's Soc. Sec. No. ______ Group No. ______ Local No. ______

***It is important that we know about 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.***

## DENTAL HISTORY

***HOW LONG SINCE*** you have seen a Dentist? ______

Date of Last ***COMPLETE*** Dental Exam ______

Date of Last ***FULL MOUTH X-RAYS:*** ______ (16 small Films or Panoramic)

| Question | YES | NO |
|---|---|---|
| Are you having ***PROBLEMS*** now? ***WHAT?*** ______ | ❒ | ❒ |
| Is your present dental health ***POOR?*** | ❒ | ❒ |
| Do you wear ***DENTURES?*** (Partials or Full) | ❒ | ❒ |
| Are you ***UNHAPPY*** with your dentures? | ❒ | ❒ |
| Would you like to know more about ***PERMANENT REPLACEMENTS?*** | ❒ | ❒ |
| Are you ***APPREHENSIVE*** about dental treatment? | ❒ | ❒ |
| Have you had any ***PERIODONTAL (GUM)*** treatments? | ❒ | ❒ |
| Do your gums ***BLEED,*** feel ***TENDER*** or become ***IRRITATED?*** | ❒ | ❒ |
| Are your teeth ***SENSITIVE*** to hot, cold, sweets, pressure? (circle) | ❒ | ❒ |
| Are you ***UNHAPPY*** with the ***APPEARANCE*** of your teeth? | ❒ | ❒ |
| Are you aware of ***GRINDING*** or ***CLENCHING*** your teeth? | ❒ | ❒ |
| Do you have ***HEADACHES, EARACHES,*** or ***NECK PAINS?*** | ❒ | ❒ |
| Have you worn ***BRACES*** on your teeth? ***(ORTHODONTICS)*** | ❒ | ❒ |
| Do you have ***DISCOLORED*** teeth that bother you? | ❒ | ❒ |
| Would you like your smile to ***LOOK BETTER*** or ***DIFFERENT?*** | ❒ | ❒ |
| Do you ***REGULARLY*** use ***DENTAL FLOSS?*** | ❒ | ❒ |

Name of Previous Dentist: ______

City: ______ State ______

How do you feel about your teeth? ______

Please ***RANK*** the following in the order in which they would ***KEEP YOU FROM*** having dental treatment.

***FEAR*** of pain # ______ ***LACK*** of concern # ______

***COST*** of treatment # ______ ***MISSING*** work time # ______

## MEDICAL HISTORY

| Question | YES | NO |
|---|---|---|
| Do you have any ***CURRENT HEALTH PROBLEMS?*** | ❒ | ❒ |
| Are you under a ***PHYSICIAN'S CARE*** now? For What? ______ | ❒ | ❒ |
| What ***MEDICATIONS*** are you currently taking? ______ | | |
| Are you ***PREGNANT?*** | ❒ | ❒ |
| Do you ***SMOKE?*** | ❒ | ❒ |

**CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:**

| | | |
|---|---|---|
| Heart Disease or Attack | AIDS/ARC/HIV Pos. | Bruise Easily |
| Angina Pectoris | Hepatitis A (infectious) | Emphysema |
| High Blood Pressure | Hepatitis B (serum) | Tuberculosis (TB) |
| Heart Murmur | Liver Disease | Asthma |
| Rheumatic Fever | Blood Transfusion | Hay Fever |
| Congenital Heart Lesions | Drug Addiction | Sinus Trouble |
| Mitral Valve Prolapse | Hemophilia (Bleeding Problems) | Allergies or Hives |
| Artificial Heart Valve | Fever Blisters | Diabetes |
| Heart Pacemaker | Epilepsy or Seizures | Thyroid Disease |
| Heart Surgery | Nervousness | Radiation Treatment |
| Artificial Joints (Hip, Knee) | Psychiatric Treatment | Arthritis |
| Anemia | Glaucoma | Cortisone Medicine |
| Stroke | Chemotherapy (Cancer, Leukemia) | Pain in Jaw Joints |
| Kidney Trouble | Venereal Disease | Alcoholism |
| Ulcers | (Syphilis, Gonorrhea, etc.) | Cosmetic Surgery |

**ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?**

| | | |
|---|---|---|
| Aspirin | Local Anesthetic | Erythromycin |
| Nitrous Oxide | Codeine | Penicillin |

Please list any other medications or substances you are allergic to? ______

Please list any other Medical or Dental information you feel we should know about: ______

FAMILY PHYSICIAN ______ PHONE NO. ______

PATIENT Signature (Parent of Child) ______ Date ______ DENTIST Signature ______

# DIAGNOSIS: MISSING TEETH and EXISTING PROBLEMS

## PERIODONTAL EXAMINATION

A B C D E | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 | F G H I J

RIGHT | LEFT

T S R Q P | 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17 | O N M L K

## TREATMENT PLAN

| DATE DIAGNOSED | TOOTH NO. | SUR-FACE | DESCRIPTION OF SERVICE | ADA CODE | FEE | CO-PAY |
|---|---|---|---|---|---|---|
| | | | EXAMINATION | | | |
| | | | X-RAY: PANORAMIC: FMX: BWX: | | | |
| | | | DIAGNOSTIC MODELS | | | |
| | | | PROPHYLAXIS (CLEANING) | | | |
| | | | QUADRANTS SCALING & CURETTAGE | | | |
| | | | NITROUS OXIDE GAS | | | |

| DATE DIAGNOSED | TOOTH NO. | SUR-FACE | DESCRIPTION OF SERVICE | ADA CODE | FEE | CO-PAY |
|---|---|---|---|---|---|---|

# COMPLETED TREATMENT

A B C D E | 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16 | F G H I J

RIGHT | LEFT

T S R Q P | 32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17 | O N M L K

## INITIAL PERIODONTAL EXAM:

| | | | |
|---|---|---|---|
| GINGIVAL INFLAMMATION: | ☐ Slight | ☐ Moderate | ☐ Severe |
| SOFT PLAQUE BUILDUP: | ☐ Slight | ☐ Moderate | ☐ Heavy |
| HARD CALC. BUILDUP: | ☐ Light | ☐ Moderate | ☐ Heavy |
| STAINS: | ☐ Light | ☐ Moderate | ☐ Heavy |
| HOME CARE EFFECTIVENESS: | ☐ Good | ☐ Fair | ☐ Poor |
| PERIODONTAL CONDITION: | ☐ Good | ☐ Fair | ☐ Poor |
| PERIODONTAL DIAGNOSIS: | ☐ Normal | ☐ Gingivitis | |
| PERIODONTITIS: | ☐ Early | ☐ Moderate | ☐ Advanced |

MUCOGINGIVAL DEFECTS #s: ____________

## INITIAL X-RAY FINDINGS:

X-RAYS TAKEN: ☐ FM-PAS ☐ BWX ☐ PANO. ☐ OTHER ________

☐ NO BONE LOSS
☐ SLIGHT BONE LOSS (04600)
☐ **MODERATE BONE LOSS (04700)**
☐ MAJOR BONE LOSS (04800)
☐ **BEGINNING FURCATION (04700)**
☐ ADVANCED FURCATION (04800)
☐ OTHER: ____________

QUADRANTS

| UR | UL | LR | LL |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## CLINICAL DATA:

OCCLUSION: ☐ Class I ☐ Class II ☐ Class III ☐ Crossbite: ________

T.M.J. EXAM: ☐ Normal ☐ Popping ☐ Deviation ☐ Tooth Wear ☐ Pain

SHADE

| Teeth | Upper | Lower |
|---|---|---|
| Cents | | |
| Lats | | |
| Cusp | | |
| Posts | | |

SEXTANT SCORE

PERIODONTAL SCREENING & RECORDING

MONTH DAY YEAR

## INITIAL SOFT TISSUE EXAM:

☐ Lips ☐ Floor of Mouth ☐ Palate ☐ Tongue ☐ Neck & Nodes

## PATIENT'S TREATMENT DECISIONS:

☐ DOCUMENTATION OF DENTAL RECORD COMPLETED

☐ PATIENT INFORMED OF TX. RECOMMENDATIONS AND CONSENTS TO TX. (ALTERNATIVES DISCUSSED.)

☐ PATIENT WANTS NO TX. OR PARTIAL TX. INFORMED OF CONSEQUENCES AND RISKS INVOLVED.

## EXISTING PROSTHESIS:

MAX. ________ DATE PLACED: ________ CONDITION: ________

MAND. ________ DATE PLACED: ________ CONDITION: ________

## REFERRALS:

PERIO: ________ ORTHO: ________ ENDO: ________

ORAL SURG: ________ M.D. ________ OTHER: ________

# NOTES

______________________________________

______________________________________

______________________________________

______________________________________

______________________________________

______________________________________

# CONSENT

The undersigned hereby authorizes the Doctor 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 my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance.

PATIENT Signature (Parent of Child) ____________ Date ________ DENTIST Signature ____________

I understand that where appropriate, credit reports may be obtained.