

PATIENT REGISTRATION AND HEALTH HISTORY

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Driver's License: _____
Marital Status (circle one) S M D O Sex: M F Spouse's Name: _____
Social Security No.: _____ Occupation: _____
Employed By: _____ Address: _____ Phone: _____
Dentist's Name: _____ Address: _____ Phone: _____
Physician's Name: _____ Address: _____ Phone: _____
Person responsible for account: _____ Address: _____ Phone: _____
Do you have dental insurance? Y N If yes, please complete the "Dental Insurance Information Form"
Who should we contact in case of an emergency?: _____
Emergency Phone No: _____ Relationship to Patient: _____
Who may we thank for referring you to our office? _____

DENTAL AND MEDICAL HISTORY

1. Are you experiencing pain from you mouth at this time? _____ If so, explain: _____
2. How many times have you had you teeth cleaned in the last 5 years? _____ When was the last time? _____
3. Have you had previous periodontal treatment? _____ Dentist, Date: _____
4. Did either your mother, father, brother or sister lose all of their natural teeth? _____ If so, when? _____
5. Are you teeth sensitive to heat, cold, or sweets? _____ Which ones? _____
6. Have you had your teeth straightened? _____ Dentist, Date: _____
7. Do you smoke? _____ What and how much? _____
8. Are you aware of grinding your teeth at night in your sleep? _____
9. Have we treated any of your family or friends? _____ Who? _____
10. Do you consider your general health to be good? _____ Fair? _____ Poor? _____
11. Has your general health changed within the past year? _____ Explain: _____
12. Have you ever fainted? _____ In a dental office? _____
13. How do you feel about going to the dentist? _____
14. Are you being treated by a physician at this time? _____ If so, why? _____
15. Are you taking any medications, drugs, or pills regularly? (please include nonprescription medication and herbal supplements) _____

16. List all childhood diseases: _____

Medical Alert (FOR OFFICE USE ONLY)

Please Fill Out Reverse Side of This Form

17. Have you ever had or do you now have any of the following? (please circle items that apply)

Anemia	High Blood Pressure	Lung Trouble	Liver Trouble	Pace Maker
Blood Disease	Low Blood Pressure	Asthma	Gland Trouble	Artificial Joint(s)
Bleeding Problems	Diabetes	Tuberculosis	Bladder Trouble	Latex Allergy
Clotting Problems	Venereal Disease	Ulcer(s)	Psychiatric Treatment	
Heart Disease	Hepatitis	Bowel Disease	Glaucoma	Stroke
Kidney Trouble	Sinus Trouble	Rheumatic Fever	Rheumatism	Excessive Thirst
Malignancy	Mitral Valve Prolapse	Epilepsy	Skin Disease	Arthritis
Thyroid Disease	Radiation	AIDS or ARC	Heart Murmur	Phen-Fen

Other _____

18. Have you ever been told to take an antibiotic before coming to dental appointments? _____

19. Have you ever taken cortisone? _____ When and for how long? _____

20. Have you taken anti-coagulants(blood thinner)? _____ When and for how long? _____

Female Patients Only – Male Patients, Please Skip to Question #23

21. Are you pregnant? _____ Which month? _____ Oral contraceptives? _____

Warning to female patients taking antibiotics: Occasionally your doctor will prescribe an antibiotic to be taken in conjunction with surgery or if an infection is present. Any patient taking oral contraceptives (birth control pills) needs to be aware that in a small number of cases, the effectiveness of their contraceptive may be diminished by the antibiotics. For this reason additional contraceptive measures are recommended during the time that the antibiotics are used and for one week after. Examples of antibiotics with such effects include: Penicillin, Ampicillin, Tetracycline and Doxycycline. As this is not a complete list of the antibiotics involved, please use additional contraceptive measures regardless of the antibiotic you are prescribed.

22. Have you reached menopause? _____ Are you taking hormones? _____

23. Circle or note the drug(s) or product(s) you have reacted adversely to:

Penicillin	Aspirin	Codeine	Sulfa	Demerol	Iodine
Versed	Valium	Barbiturates	Darvon	Vicodin	Bananas
Local Anesthetics	Tetracycline	Antihistamines	Phenergan	Doxycycline	Avocados

Other: _____

24. Do you bruise easily? _____

25. Have you had major surgery? _____ When? _____ Any complications? _____
For what? _____

26. Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your periodontal care: _____

I also authorize Dr. Michael J. Brenegan and his staff to share pertinent medical and dental information with my dentist

Signature Date Witness Date