HEALTH HISTORY & REGISTRATION

CHART # ___________

PATIENT INFORMATION

Patient's Name (Last)_________________________ (First)__________________________ Middle Initial______
Birth date __________________________

Who May We Thank for Referring You to our Office?____
Reason for this visit____

RESPONSIBLE PARTY INFORMATION

Name (Last)_________________________________ (First)__________________________ Middle Initial______
Address (Street)____ Apt#_______
City____________________________ State_______ Zip___________

Home Phone ( )_____-_______ Cell Phone ( )_____-_______ Work Phone ( )_____-_______
Email____________________________________
Emergency Contact: ____ Phone ( ) _____-________

MEDICAL HISTORY

Are you pregnant? Yes / No If yes, how many mo:____
Do you have any current health problems? Yes / No If yes, please explain: ____
Are you under a physician's care now? Yes / No If yes, please explain: ____
Do you use cigar/cigarettes, pipe, or chewing tobacco? Yes / No

What medications are you taking? None / List:____
____

Are you allergic to or have you reacted adversely to any of the following medications? Yes / No If yes, please circle below.

Local Anesthetic	Penicillin	Erythromycin	Codeine	Nitrous Oxide
Latex	Aspirin	Ibuprofen	Sulfa Drugs	

Are you allergic to or have you reacted adversely to any other medication, material, foods, etc...? Yes / No List: ____
____

Have you ever taken (circle) Fen-Phen / Redux? Yes / No If yes, when:____
Have you ever had Heart Surgery or Prosthetic Heart Valve? Yes / No If yes, when:____
Have you had surgery for any Prosthetic Joints? Yes / No If yes, when: ____

Have you taken Bisphosphonates (Drugs for Osteoporosis (circle): Fosamax, Actonel, or Boniva)? Yes / No Other medication: ________________________________
Have you ever had Radiation treatment? Yes / No If yes, where? ___________________________________
Have you ever had medication for the treatment of Cancer or Tumor? Yes / No If yes, where? ___________________________________
Please √ Yes or No of the Following which you have had or presently have:

	Yes	No		Yes	No		Yes	No
AIDS/HIV	☐	☐	Fainting	☐	☐	Psychiatric Care	☐	☐
Anaphylaxis	☐	☐	Food Allergies	☐	☐	Rapid weight gain/loss	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Radiation treatment	☐	☐
Arthritis	☐	☐	Headaches	☐	☐	Respiratory Disease	☐	☐
Artificial heart valve	☐	☐	Heart Murmur	☐	☐	Rheumatic/scarlet fever	☐	☐
Artificial Joints	☐	☐	Heart Problem/Surgery	☐	☐	Shingles	☐	☐
Asthma	☐	☐	describe ___________________			Shortness of Breath	☐	☐
Atopic (allergy prone)	☐	☐	Hemophilia (abnormal bleeding)			Skin Rash	☐	☐
Back Problems	☐	☐	Herpes	☐	☐	Spina Bifida	☐	☐
Blood Disease	☐	☐	Hepatitis	☐	☐	Stroke	☐	☐
Cancer	☐	☐	High Blood Pressure	☐	☐	Surgical Implant	☐	☐
Chemical Dependency	☐	☐	Jaw Pain	☐	☐	Swelling of Feet or Ankles	☐	☐
Chemotherapy	☐	☐	Kidney	☐	☐	Thyroid Disease or Malfunction	☐	☐
Circulatory Problems	☐	☐	Liver Disease	☐	☐	Tobacco Habit	☐	☐
Cortisone Treatments	☐	☐	Material Allergies	☐	☐	Tonsillitis	☐	☐
Cough (persistant)	☐	☐	(latex, wool, metal, chemical)			Tuberculosis	☐	☐
Cough Up Blood	☐	☐	Mitral Valve Prolapse	☐	☐	Ulcer / Colitis	☐	☐
Diabetes	☐	☐	Nervous Problems	☐	☐	Venereal Disease	☐	☐
Epilepsy	☐	☐	Pace Maker	☐	☐			

Patient Signature (Parent of Child) _______________________________Date _________ Dentist Signature __________________