Highline Dental Practice

Adult Registration & History **Date…….**

Name…….……
Street Address……
City…….
State…….Zip…….
Home phone #……....
Cellular phone #……
E-mail address…….@……..
Social Security #……
Date of Birth……..
Marital Status: S M D W
Employer……
Business Address……
Co…….Group#……
Business Phone……..
Position……...

Spouse's Name……
Spouse's Employer……..
Business Phone#……
Position……

Who is responsible for the payment of this account?……..
Do you have dental insurance?……..
Are you covered by more than one dental insurance company?…….
Name of first insured person…….
SS#……..D.O.B……..
Insurance Co……..Group#…….

Name of second insured person……..
SS#…….D.O.B…….
Insurance

Who may we thank for referring you to our office?……
…….
…….

DENTAL HISTORY

What prompted you to seek dental care at this time?……
……..

How long has it been since your last dental exam and cleaning?…….

For routine dentistry, do you normally have Novacaine?……

For routine dentistry, do you normally have Nitrous Oxide (sweet air,laughing gas)?…….

Do you use dental floss daily?…….

Have you ever had any trauma or injury to your teeth?……..

Has any treatment ever been suggested that was never done?……..
If so, please explain……
..……

Have you ever had an unusual reaction to dental anesthesia?……..

Please print YES or NO to all of the following:

Frequent headaches……..
Dizziness…….
Jaw or facial muscles tight on awakening…….
Ringing in the ears…….
Stuffiness in the ears……..
Clenching/Grinding your teeth……..

Please indicate below what things you look for when choosing your dentist:

Explains things so I understand them.
Is aware of my financial concerns.
Has a pleasant staff.
Keeps me and my family informed about new trends in dentistry.
Cares about me.
Has a good appearance.
Is gentle when working in my mouth.
Is on time for my appointment.
Other……..

MEDICAL HISTORY

Physician's Name_____Phone #_____
Address_____Date of last physical exam_____

PLEASE PRINT "YES" OR "NO" TO THE FOLLOWING QUESTIONS:

Indicate your general physical condition:
__Excellent __Good __ Fair __ Poor
Are you being treated for anything now?
_____
If yes, describe_____
Prolapse_____
Are you taking any medication now?____
If yes, please list_____
Have you ever been treated for cancer?___
Are you subject to prolonged bleeding?___
Do you bruise easily?_____
Do you smoke?_____
Is you blood pressure
___high ___low ___normal
Do you wear a pacemaker?_____

Women Only

Do you use birth control pills?_____
(Antibiotics we prescribe can render birth control pills ineffective)
Are you pregnant?_____
What is your due date?_____
Name of Obstetrician_____
Phone #_____

HAVE YOU EVER HAD:

Diabetes…….. _____
Heart trouble……..
Heart Murmur/MitralValve
Rheumatic Fever…… _____
Stroke……. _____
Venereal Disease…… _____
Anemia/Blood disorder……. _____
Tuberculosis…….. _____
Seizures……. _____
Psychiatric treatment……_____
Asthma……..…. _____
Emphysema…… _____
Ulcers……. _____
Kidney or Liver trouble……. _____
H.I.V. Positive/ AIDS…… _____
Hepatitis……Type……_____
Alcohol/Drug abuse or addiction…..._____
Joint Replacement……. _____
Blood thinners…….. _____
Are you allergic to Latex?…… _____

Please list any allergies to foods or medications OR write "NONE"……

……..

Please add any information you feel is important:

I certify that I have truthfully filled in the above information and that I will inform this office at subsequent visits of any changes in my health or medications.

Patient's signature_____Date_____

Doctor/Hygienist signature_____Date_____ _