

PATIENT REGISTRATION AND HEALTH HISTORY REVIEW

SELF: Date _____
Patient's Full Name _____ How do you prefer to be addressed? _____
Address _____ Home Phone # _____
City _____ State _____ Zip _____ Work # & Ext. _____
Male or Female _____ Single () Widowed () Married () Divorced () Separated ()
SS# _____ Date of Birth ____/____/____
Who may we thank for telling you about our office? _____
Employed By _____ How long _____
Driver's License # _____ Names of your children _____

SPOUSE AND/OR RESPONSIBLE PARTY:

Full Name _____ Birthdate ____/____/____
Employed By _____ Work # & Ext. # _____
Home Address (if different than patient) _____
SS# _____ Driver's License # _____
In case of emergency, who should be notified? _____ Phone # _____

CORRECT ANSWERS TO THE FOLLOWING QUESTIONS WILL ALLOW DR. ANDERS AND OUR TEAM TO TREAT YOU ON A MORE INDIVIDUAL BASIS, PROVIDING THE CARE APPROPRIATE FOR YOUR PARTICULAR NEEDS. ALL INFORMATION WILL BE KEPT CONFIDENTIAL.

DENTAL HISTORY

Purpose of this appointment: _____
Have you ever had serious trouble associated with dental treatment? (Y)(N)
Explain: _____
Are you concerned about any materials or procedures in your mouth? (Y) (N)
Do you have fluoride in your drinking water? (Y)(N)
Date of last dental visit? _____ Last dental x-rays? _____ Did you visit your dentist on a regular basis?(Y)(N) Please give us the name of your previous dentist _____
Address: _____
Have you ever fainted during a dental appointment? (Y)(N) Does your physician require you to take antibiotics prior to dental work? (Y)(N) Does dental treatment make you nervous? No Slightly Moderately Extremely

Do you or have you had any of the following? Circle yes or no.

Periodontal disease (Pyorrhea) (Y)(N)	Tooth Sensitivity (Y)(N)	Dental Pain (Y)(N)
Difficulty opening/closing jaws (Y)(N)	to hot/cold (Y)(N)	Dental Fear (Y)(N)
Bleeding/sore gums (Y)(N)	to sweets (Y)(N)	Loose Teeth (Y)(N)
Unpleasant taste/bad breath (Y)(N)	to biting (Y)(N)	Snoring (Y)(N)
Clenching/Grinding teeth (Y)(N)	Food impaction (Y)(N)	Braces (Y)(N)

These are the things that are important to me about my dental health:

I **a)** think the appearance of my mouth/smile is excellent **b)** am satisfied with the appearance of my mouth/smile
c) am dissatisfied with the appearance of my mouth/smile.
I **a)** will do anything to keep my natural teeth **b)** want to keep my natural teeth, but have a certain budget of time and money that I am willing to spend on them. **c)** don't think my teeth can be saved.
I **a)** have always done the best that was recommended for my dental health **b)** have not done what dentists have recommended to me **c)** rarely go and don't care much about having any dental work completed.
I think my present state of dental health is **a)** Excellent **b)** Good **c)** Poor.
If you could change your smile, what would you want to be different? _____

MEDICAL HISTORY

Circle Allergies You have: Penicillin Erythromycin Novocaine Codeine Aspirin
Metal Jewelry Latex Other Allergies
Have you lost or gained more than 10 lbs. in recent months? (Y)(N) Had a persistent cough for more than 3 weeks? (Y)(N) Had night sweats? (Y)(N) Coughed up blood? (Y)(N)
Are you under the care of a Physician?(Y)(N) If yes, for what conditions? _____
Have you been hospitalized/had a serious illness in the last 5 years? (Y)(N)
Explain: _____
Have you ever had surgery/radiation or chemotherapy for a tumor, growth or other condition in your mouth, lips, neck or face? (Y)(N) Explain: _____
Please give your Physician's Name: _____ Last physical _____
Physician's Phone # _____ Address: _____

Please continue to other side of this form

Do you drink more than 2 alcoholic beverages a day? (Y)(N)
 Do you use tobacco products? (Y)(N) What form? _____ How Much? _____ How Long? _____
 Are you pregnant or trying to get pregnant or nursing? (Y) (N) Due date: _____
 Have you had any fever blisters/canker sores on your lips, gums or body? (Y)(N)
 Pain in chest upon exertion? (Y)(N) Short of breath after mild exercise? (Y)(N)

Do you or have you had any of the following? Check yes or no

Nose/Throat Infection	(Y) (N)	Cardiac pacemaker	(Y) (N)	Epilepsy	(Y) (N)
*Congestive heart disease	(Y) (N)	Lung disease	(Y) (N)	Herpes	(Y) (N)
Rheumatic fever	(Y) (N)	Sinus trouble	(Y) (N)	AIDS	(Y) (N)
*Artificial heart valve	(Y) (N)	Diabetes	(Y) (N)	Stroke	(Y) (N)
Thyroid problems	(Y) (N)	HIV positive	(Y) (N)	Ulcer	(Y) (N)
*Bacterial endocarditis	(Y) (N)	Heart murmur	(Y) (N)	Jaundice	(Y) (N)
Heart trouble/attack	(Y) (N)	Cancer treatment	(Y) (N)	Anemia	(Y) (N)
High blood pressure	(Y) (N)	Kidney treatment	(Y) (N)	Asthma	(Y) (N)
Psychiatric care	(Y) (N)	Tuberculosis	(Y) (N)	Hepatitis	(Y) (N)
Circulation problems	(Y) (N)	Blood transfusion	(Y) (N)	Arthritis	(Y) (N)
Do your ankles swell?	(Y) (N)	Skin disease	(Y) (N)	Headaches	(Y) (N)
*Artificial hip, knee or other joint	(Y) (N)	Mental Retardation	(Y) (N)	Alcoholism	(Y) (N)
Glaucoma	(Y) (N)	Hemophilia	(Y) (N)	Drug addiction	(Y) (N)
*Any type of transplant	(Y) (N)	* Antibiotic pre-medication may be required prior to appointment			

Please use this space to list dates and circumstances for any serious problems that you have checked above:

Is there any condition or problem not listed above that we should know about or any activity your physician says you can not do? Explain:

Have you ever taken **Fen-Phen**? (Y) (N) **Emsam** ? (Y) (N) **Azobactin**? (Y) (N)

List names of medication (prescription or illegal) you are currently taking and dosage below: (Including patches, inhaler or injections as well as birth control pills, AZT or other drugs for HIV)

1. _____ 2. _____ 3. _____
 4. _____ 5. _____ 6. _____

If you are **taking antidepressants, especially Emsam or Strattera**, you will find that you will not stay anesthetized for long and it is not usually beneficial to use anesthetics that contain epinephrine. **This is also true for medications to treat: ADD/ADHD, Narcolepsy, Obesity, Enuresis, Decongestion, Sleep Disorders, Antipsychotics, Beta Blockers, MAOI's and Bronchodilators.**

To the best of my knowledge, all of the preceding answers are correct. I understand that antibiotics may reduce the effectiveness of birth control pills and I should use alternative forms of birth control if I have to take antibiotics. If I have any changes in my health or medications, I will inform your office at my next appointment.

I understand that I will be responsible for any legal and/or collection fees. I understand and agree that I am ultimately responsible for payments of professional services regardless of whether I have dental insurance.

I authorize any hospital, clinic, physician or surgeon to furnish Dr. Anders or her staff with any and all information concerning any medial problems or infectious diseases, and alcohol and drug problems that I possess. Copies of my medical records may be sent to Dr. Anders' office. A copy of this authorization shall be considered as valid as the original.

SIGNATURE: _____

- I give my approval for a Credit Report to be obtained regarding my credit history in order to qualify for financial arrangement.
- I do not consent for a Credit Report. I understand that if I don't give approval that credit or payment arrangements can not be extended to me and that payment for service is due at each visit in full (regardless of whether I have dental insurance).

SIGNATURE: _____

Our team is dedicated to the idea that all people should have the knowledge to retain their natural teeth for their lifetime. Preventive measures, high quality care, and cooperation combined with timely treatment make it possible for most people to retain their natural teeth with optimum comfort, function, and appearance. We will do everything we can to help you reach your goals for dental health.