PATIENT REGISTRATION

_________________ __________________ _____Male Female BIRTHDATE:___________

Last **First** **MI**

ADDRESS:___________________________CITY____________STATE_______ZIP_________
HOME #:( )______________WORK #:( )_______________CELL #:( )___________
EMPLOYED BY:____HOW LONG_________
OCCUPATION:____Email:_______________
MARITAL STATUS: ☐MARRIED ☐SINGLE ☐DIVORCED ☐SEPARATED ☐WIDOW ☐MINOR
IF STUDENT, NAME OF SCHOOL ATTENDING:______________________CITY__________
REFERRED BY:________ ________PHYSICIAN:________ ________
First Name Last Name First Name Last Name

HAVE YOU OR ANY OTHER FAMILY MEMBERS BEEN TREATED IN THIS OFFICE BEFORE?
YES☐ NO☐ LIST____

PERSON RESPONSIBLE FOR BILL (If Not Self)

NAME OF RESPONSIBLE PARTY:_______________ _______________RELATION:_____________
First Name Last Name
ADDRESS:____________________/________________/___/___________SOC. SEC. #:____________
Street City State Zip
EMPLOYER/ADDRESS :_______________________________________HOW LONG:___________
HOME PHONE:( )______________________WORK PHONE: ( )______________________

NAME OF SPOUSE OR OTHER PARENT NOT LISTED ABOVE

SPOUSE / PARENTS NAME:_________________________________RELATION:_____________
ADDRESS:___________________/_______________/___/___________WORK PHONE:____________
Street City State Zip
EMPLOYED BY:____HOW LONG:______________

IN CASE OF EMERGENCY, PERSON TO CONTACT OTHER THAN PARENT / SPOUSE

NAME:____RELATION:_______________
ADDRESS:____PHONE: ( )_____________

PAYMENT: CASH INSURANCE CREDIT CARD OREGON HEALTH PLAN

PRIMARY INSURANCE INFORMATION

POLICYHOLDER:_________ _________SOC. SEC. #:________________BIRTHDATE:_________
First Name Last Name

DENTAL INSURANCE

INSURANCE CO.:_______________________
INS. CO. ADDRESS:____________________
City/State/Zip:_________________/___/______
INS. CO. PHONE #:(____)_________________
GROUP #:_____________ ID #:____________

MEDICAL INSURANCE

INSURANCE CO.:__________________________
INS. CO. ADDRESS:________________________
City/State/Zip:__________________/___/________
INS. CO. PHONE #:(____)______________________
GROUP #:_____________ ID #:________________

SECONDARY INSURANCE INFORMATION

POLICYHOLDER:_________ _________SOC. SEC. #:________________BIRTHDATE:_________
First Name Last Name

DENTAL INSURANCE

INSURANCE CO.:_______________________
INS. CO. ADDRESS:____________________
City/State/Zip:_________________/___/______
INS. CO. PHONE #:(_____)______________
GROUP #:_____________ ID #:___________

MEDICAL INSURANCE

INSURANCE CO.:__________________________
INS. CO. ADDRESS:________________________
City/State/Zip:__________________/___/________
INS. CO. PHONE #:(______)___________________
GROUP #:_____________ ID #:________________

HEALTH HISTORY

Patient's Name ________________ Date ________________

1. Are you in good health? .... Y☐ N☐
2. Has there been any change in your general health in the past year? .... Y☐ N☐
3. Date of last physical exam ____________________
4. Are you now under a physician's care for a particular problem? .... Y☐ N☐
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: .... Y☐ N☐
   ____
   ____
6. Height _____ Weight ______
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease?..... Y☐ N☐
   - B. Congenital Heart Disease? .... Y☐ N☐
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur (Mitral Valve Prolapse, Rheumatic fever), Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) .... Y☐ N☐
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain?.......................... Y☐ N☐
   - E. Obstructive Sleep Apnea, C-PAP .... Y☐ N☐
   - F. Seizures, Convulsions, Epilepsy, Fainting or Dizziness .... Y☐ N☐
   - G. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?............ Y☐ N☐
   - G. Liver Disease (Jaundice, Hepatitis)? .... Y☐ N☐
   - H. Kidney Disease? .... Y☐ N☐
   - I. Diabetes?.. Y☐ N☐
   - J. Thyroid Disease (Goiter)? .... Y☐ N☐
   - K. Arthritis?.. Y☐ N☐
   - L. Stomach Ulcers or Colitis?..................................... Y☐ N☐
   - M. Glaucoma? .... Y☐ N☐
   - N. Implants or artificial joints placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? .. Y☐ N☐
   - O. Radiation (X-ray) treatment for Cancer? .... Y☐ N☐
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?...... Y☐ N☐
   - Q. Sinus or Nasal problems?...................................... Y☐ N☐
   - R. Any disease, drug or transplant operation that has depressed your immune system? .... Y☐ N☐
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? .... Y☐ N☐
   - B. Anticoagulants (Blood Thinners)?.......................... Y☐ N☐
   - C. Aspirin or drugs such as Aleve, Ibuprofen? .... Y☐ N☐
   - D. High Blood Pressure medications?........................ Y☐ N☐
   - E. Steroids (Cortisone, Prednisone, etc.)? .... Y☐ N☐
   - F. Tranquilizers? .... Y☐ N☐
   - G. Insulin or Oral Anti-Diabetic drugs? .... Y☐ N☐

   List your dental concerns:

   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? .... Y☐ N☐
   - I. Have you ever taken a Bisphosphonate (Aredia, Zometa, Actonel, Boniva, Fosamax, Skelid, Didronel)?........ Y☐ N☐
   - J. Have you ever had a Bisphosphonate Reclast Injection?... Y☐ N☐
   - K. Please list any and all medications taken, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:
9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? .... Y☐ N☐
   - B. Penicillin or other antibiotics? .... Y☐ N☐
   - C. Sedatives, Barbiturates, Sulfites? .... Y☐ N☐
   - D. Aspirin or Ibuprofen? .... Y☐ N☐
   - E. Codeine or other pain killers? .... Y☐ N☐
   - F. Latex or Rubber Products? .... Y☐ N☐
   - G. Eggs or Soybeans?... Y☐ N☐
   - H. Other allergies or reactions? Please, list .... Y☐ N☐
10. Do you smoke or chew Tobacco? .... Y☐ N☐
    How much per day? _________
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? .... Y☐ N☐
12. Do you use recreational drugs? List .... Y☐ N☐
13. Have you had any serious problems associated with any previous dental treatment? .... Y☐ N☐
14. Have you or an immediate family member had any problem associated with anesthesia?........................... Y☐ N☐
15. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? .... Y☐ N☐
16. Do you wish to talk to the doctor privately about anything?.. Y☐ N☐
17. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **is there any chance** you might be Pregnant? .... Y☐ N☐
    - B. Are you nursing? .... Y☐ N☐
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

Date ________________ Signature of Person Completing Health History ________________ Dentists Initials ________________

Medical Update: I have read my Health History dated ____________________ and confirm that it adequately states past and present conditions.

Date	Exceptions or changes	Patient's Signature	Doctor's Initials