



PATIENT REGISTRATION & HEALTH HISTORY FORM

Date: _____

PATIENT INFORMATION

First Name: _____ M: _____

Is the patient a student? Full Time Part Time

Last Name: _____

Employer: _____

Preferred Name: _____

Phone: _____

Address: _____

Occupation: _____

City: _____ State: _____ Zip Code: _____

Employer Address: _____

Date of Birth: _____

Gender: _____ Is the patient a minor? Yes

Spouse's Name: _____

Relationship Status: Single Partnered Married

Date of Birth: _____

Divorced Widowed

How did you hear about us?: _____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to patient: _____

Insurance Co: _____

Group #: _____

Subscriber ID/SSN: _____

Is patient covered by additional insurance? Yes No

Subscriber's Name: _____

Date of Birth: _____

Relationship to patient: _____

Insurance Co: _____

Group #: _____

Subscriber ID/SSN: _____

ASSIGNMENT AND RELEASE. I certify that I, and/or my dependents have insurance coverage with _____ and assign directly to Salem Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above name dental practice may use my health care information and may disclose such information to the above named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date

Relationship to Patient

CONTACT INFORMATION *REQUIRED INFORMATION*

*Cell Phone (_____) _____ Is it okay to send text messages for appointment confirmations and reminders? Yes No

*Email Address: _____ This is used for appointment reminders/confirmations. This is never used for spam or given out to anyone else.

Home Phone (_____) _____ Work Phone (_____) _____ Best time and place to reach you: _____

Emergency Contact: Name _____ Relationship _____ Phone (_____) _____

DENTAL HISTORY

Reason for today's visit: _____

Date of last dental visit: _____

Date of last dental X-rays: _____

Do you have bleeding gums? Yes No

Do you use any form of tobacco?

Do you have dry mouth?

Does food collect between your teeth?

Do you grind your teeth?

Any loose teeth or fillings?

Do you have any jaw pain?

SMILE EVALUATION

Would you like your teeth to be straighter? Yes No

Would you like your teeth to be whiter?

Have you noticed any wear or chipping of your teeth?

If there is anything you could change about your teeth, what would it be?

SLEEP HEALTH

Do you snore? Yes No

Do you wakeup not feeling refreshed?

Do you wakeup in the morning with headaches?

Is it hard to stay awake during the day?

HEALTH HISTORY

Yes No

- AIDS/HIV
 Anemia
 Anxiety
 Arthritis, Rheumatism
 Asthma
 Back Problems
 Blood Disease
 Cancer
 Chemical Dependency
 Chemotherapy
 Circulatory Problems
 Cortisone Treatments
 Diabetes
 Emphysema
 Epilepsy
 Fainting or dizziness
 Glaucoma
 Headaches
 Hepatitis Type _____

Yes No

- Herpes
 High Blood Pressure
 Jaundice
 Kidney Disease
 Liver Disease
 Low Blood Pressure
 Nervous System Problems
 Psychiatric Care
 Radiation Treatment
 Respiratory Disease
 Shortness of Breath
 Sinus Trouble
 Swollen Neck Glands
 Thyroid Problems
 Tonsillitis
 Tuberculosis
 Tumor or growths on head
 Ulcer

Yes No

- Artificial Heart Valves
 Artificial Joints
 Abnormal Bleeding After Surgery
 Congenital Heart Lesions
 Heart Murmur
 Mitral Valve Prolapse
 Pacemaker
 Rheumatic Fever
 Scarlet Fever
 Stroke
 Premedication needed for dental visits?
 Are You Pregnant?

Other Heart Problems: _____

Other Medical Conditions: _____

MEDICATIONS

Please list any medications that you are currently taking:

Physician Name: _____

Physician Location: _____

Physician Phone: _____

ALLERGIES

	Yes	No
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>
Iodine	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>
Local Anesthetic	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
Reaction to metals	<input type="checkbox"/>	<input type="checkbox"/>

Other/Details: _____

The undersigned hereby authorizes the doctors and staff at Salem Dental to perform dental exams, take x-rays, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize the doctors at Salem Dental to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize the use of anesthetics and understand that use of anesthetics embodies a certain risk.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Sign here: _____ Date: _____

Doctor: _____ Date: _____