jurupa dentistry

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Dental Registration and Health History

Personal History

Patient's Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Sex: M / F Birth Date: _____ Age: _____ SS#: _____

Please Circle One: Single Married Widowed Separated Divorced

Cell Phone: _____ E-Mail: _____

Home Phone: _____ Work Phone: _____

Whom may we thank for referring you? _____

Primary Insurance Information

Policy Holder's Name: _____ Birth Date: _____

Relationship to Patient: _____ SS#: _____

Name of Employer: _____ Responsible for Account (Guarantor) ☐ Yes ☐ No

Insurance Co.: _____ Group#: _____

Member/Subscriber ID#: _____

Secondary Insurance Information

Policy Holder's Name: _____ Birth Date: _____

Relationship to Patient: _____ SS#: _____

Name of Employer: _____ Responsible for Account (Guarantor) ☐ Yes ☐ No

Insurance Co.: _____ Group#: _____

Member/Subscriber ID#: _____

Answers to the following questions are for our records only and will be considered confidential.

1. Date of last physical examination: _____ Physician's Name: _____
2. Is there anything you would like to speak with the Doctor about in private? ☐ Yes ☐ No
3. Have you been hospitalized in the past two years? ☐ Yes ☐ No
4. Have you taken any medications or drugs in the past two years? ☐ Yes ☐ No
5. Have you ever taken Redux or Pondimin (Fen Phen)? ☐ Yes ☐ No

Current List of Medications: _____

Allergies

Aspirin: ☐Yes ☐No	Local Anesthesia: ☐Yes ☐No	Barbiturate: ☐Yes ☐No
Iodine: ☐Yes ☐No	Codeine: ☐Yes ☐No	Sulfa: ☐Yes ☐No
Penicillin: ☐Yes ☐No	Erythromycin: ☐Yes ☐No	Latex: ☐Yes ☐No
Metals: ☐Yes ☐No	Other: _____	

Place a mark on yes or no to indicate if you have had any of the following:

Alcoholism	☐Yes ☐No	Artificial Joints	☐Yes ☐No	Chemotherapy	☐Yes ☐No
Anemia	☐Yes ☐No	Asthma	☐Yes ☐No	Chest Pains	☐Yes ☐No
Angina Pectoris	☐Yes ☐No	Birth Defects	☐Yes ☐No	Cold Sores	☐Yes ☐No
Any Implants	☐Yes ☐No	Blood Transfusions	☐Yes ☐No	Congenital Heart	☐Yes ☐No
Any Transplant	☐Yes ☐No	Bruise Easily	☐Yes ☐No	Dentures/Partials	☐Yes ☐No
Arthritis	☐Yes ☐No	Cancer	☐Yes ☐No	Diabetes	☐Yes ☐No
Drug Addiction	☐Yes ☐No	Hepatitis A	☐Yes ☐No	Persistent Cough	☐Yes ☐No
Eating Disorder	☐Yes ☐No	Hepatitis B	☐Yes ☐No	Psychiatric Therapy	☐Yes ☐No
Emphysema	☐Yes ☐No	Hepatitis C / Other	☐Yes ☐No	Radiation Therapy	☐Yes ☐No
Epilepsy/Seizures	☐Yes ☐No	Herpes Simplex	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Fainting/Dizziness	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Shortness of Breath	☐Yes ☐No
Glaucoma	☐Yes ☐No	Hives or Skin Rash	☐Yes ☐No	Sickle Cell Anemia	☐Yes ☐No
Hay Fever	☐Yes ☐No	Jaundice	☐Yes ☐No	Steroid Treatment	☐Yes ☐No
Heart Attack	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Stroke (CVA)	☐Yes ☐No
Heart Disease	☐Yes ☐No	Liver Disease	☐Yes ☐No	Thyroid Disease	☐Yes ☐No
Heart Murmur	☐Yes ☐No	Mental Retardation	☐Yes ☐No	Tobacco Use	☐Yes ☐No
Heart Surgery	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Hemophilia	☐Yes ☐No	Pacemaker	☐Yes ☐No	Ulcers	☐Yes ☐No

Have you ever experienced any of the following problems with your jaw?

Clicking/Clenching/Grinding	☐Yes	☐No
Pain in or around ears and/or headaches	☐Yes	☐No
Difficulty opening or closing or chewing	☐Yes	☐No
Do you have history of trauma to your jaw	☐Yes	☐No
Have you ever been diagnosed with TMJ/TMD	☐Yes	☐No

Do you have any of the problems listed below?

Swelling / Bleeding Gums ☐Yes ☐No

Bad Taste (Halitosis) ☐Yes ☐No

Loose Teeth ☐Yes ☐No

Do you have sensitivity to:

Temperature (Hot or Cold) ☐Yes ☐No

Biting / Pressure ☐Yes ☐No

Sweet / Tart Flavors ☐Yes ☐No

Have you ever had any sores, lumps or growths in or near your mouth?	☐Yes	☐No
Have you ever had prolonged bleeding following extractions?	☐Yes	☐No
Does food collect between your teeth?	☐Yes	☐No
Have you ever needed to see a Periodontist (Gum Specialist)?	☐Yes	☐No
Do you now have bleeding gums or any other gum conditions?	☐Yes	☐No
Are you having any pain or discomfort at this time?	☐Yes	☐No
Do you feel nervous about having dental treatment?	☐Yes	☐No
Have you ever had a bad experience in a dental office?	☐Yes	☐No
Is there anything you dislike about your smile?	☐Yes	☐No
Have you ever been told that you snore while sleeping?	☐Yes	☐No

Is there anything related to your medical and/or dental history that you have not indicated above?

_____

For Women:

Are you taking oral contraceptives?	☐Yes	☐No
Are you **pregnant** now?	☐Yes	☐No
If yes, when is your due date?_____		
Are you currently breast-feeding?	☐Yes	☐No

I certify that I have read and understood the above information, and that the above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information (including diagnosis and records of any treatment or examination rendered to me or my child) to third party payers and/or healthcare practitioners. I authorize and request my insurance company to directly reimburse the dentist or dental group any benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf, or on behalf of my dependents.

X_____

Signature of Patient or Guardian **Date**

X_____

Signature of Dentist **Date**