



# Mid-Valley Dental Care

Patient Number \_\_\_\_\_

## HEALTH HISTORY & REGISTRATION

### PATIENT INFORMATION

TODAY'S DATE \_\_\_\_\_

PATIENT'S NAME Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_

Sex M F DOB \_\_\_\_\_ Age \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Who May We Thank for Referring You to Our Office \_\_\_\_\_

Reason for this Visit \_\_\_\_\_

RESIDENCE \_\_\_\_\_ Apt. # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_ Apt. # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

HOW LONG AT THIS ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

WORK PHONE \_\_\_\_\_ E-MAIL \_\_\_\_\_

PREVIOUS ADDRESS( if less than 3 years) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ How Long \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ DOB \_\_\_\_\_ DRIVER'S LIC. # \_\_\_\_\_ RELATION TO PATIENT \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ NO. YEARS EMPLOYED \_\_\_\_\_

### Person Financially Responsible for Account (if other than patient)

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Social Security No. \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Driver's License no. \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address (Street, City, State, Zip) \_\_\_\_\_ Email: \_\_\_\_\_

Employer \_\_\_\_\_ Work phone ( ) \_\_\_\_\_

### DENTAL INSURANCE

#### Primary Carrier

Insurance co. name \_\_\_\_\_ Insurance co. phone \_\_\_\_\_

Address (Street, City, State, Zip) \_\_\_\_\_

Group no. (Plan or Policy no.) \_\_\_\_\_ Insured's I.D. no. \_\_\_\_\_

Insured's name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Date of birth \_\_\_\_\_ Insured's social security no. \_\_\_\_\_

Insured's employer name \_\_\_\_\_ Is insured a patient in our practice?  Yes  No

#### Secondary Carrier

Insurance co. name \_\_\_\_\_ Insurance co. phone \_\_\_\_\_

Address (Street, City, State, Zip) \_\_\_\_\_

Group no. (Plan or Policy no.) \_\_\_\_\_ Insured's I.D. no. \_\_\_\_\_

Insured's name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Date of birth \_\_\_\_\_ Insured's social security no. \_\_\_\_\_

Insured's employer name \_\_\_\_\_ Is insured a patient in our practice?  Yes  No

Payment is due in full at the time of treatment  
(Unless prior arrangements have been approved)

I understand that I am responsible for payment of services rendered and also responsible for paying co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment.

I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Any unpaid balance after 60 days will accrue 1.5% interest monthly (18% annually) I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency that may release such information to you. I will notify the dentist of any changes in my health or medication.

Signature \_\_\_\_\_ Date \_\_\_\_\_

#### Person to contact in case of emergency

Name \_\_\_\_\_ Relationship \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Cell phone \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

|                              | YES                      | NO                       |
|------------------------------|--------------------------|--------------------------|
| Heart Murmur.....            | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral valve prolapse.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial heart valves..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic fever.....         | <input type="checkbox"/> | <input type="checkbox"/> |

|                               | YES                      | NO                       |
|-------------------------------|--------------------------|--------------------------|
| Cardiovascular disease.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Angina.....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Arteriosclerosis.....         | <input type="checkbox"/> | <input type="checkbox"/> |
| Congestive heart failure..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Coronary artery disease.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Damaged heart valves.....     | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart attack.....             | <input type="checkbox"/> | <input type="checkbox"/> |
| Low blood pressure.....       | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure.....      | <input type="checkbox"/> | <input type="checkbox"/> |
| Congenital heart defects..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Pacemaker.....                | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic heart disease.....  | <input type="checkbox"/> | <input type="checkbox"/> |

|   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| Chest pain upon exertion:<br>can you walk up two flights of stairs<br>comfortably?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic pain.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes Type I or II.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Eating disorder.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Malnutrition.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Gastrointestinal disease.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| G.E. Reflux / persistent.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Heartburn.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Ulcers.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid problems.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis, jaundice of liver disease.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting spells or seizures.....  | <input type="checkbox"/> | <input type="checkbox"/> |

|  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| Abnormal bleeding.....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood transfusion.....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, date _____                                 |                          |                          |
| Hemophilia.....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV infection.....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis.....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Autoimmune disease.....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatoid arthritis.....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Systemic lupus erythematosus.....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Bronchitis.....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema.....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus trouble.....                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis.....                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer / Chemotherapy /Radiation<br>Treatment..... | <input type="checkbox"/> | <input type="checkbox"/> |

|   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| Neurological disorder.....                | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, Specify: _____                    |                          |                          |
| Sleep disorder.....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental health disorder.....               | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, Specify: _____                    |                          |                          |
| Recurrent infections.....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Specify Type: _____                       |                          |                          |
| Kidney problems.....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Night sweats.....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Osteoporosis.....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent swollen glands<br>in neck..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Severe headaches / migraines.....         | <input type="checkbox"/> | <input type="checkbox"/> |
| Severe or rapid weight loss.....          | <input type="checkbox"/> | <input type="checkbox"/> |
| Sexually transmitted disease.....         | <input type="checkbox"/> | <input type="checkbox"/> |
| Excessive urination.....                  | <input type="checkbox"/> | <input type="checkbox"/> |

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?.....  YES  NO

Name of physician or dentist making recommendations: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have any disease, condition, or problem not listed above that you think I should know about?.....  YES  NO

**NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his or her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his or her staff, responsible for any action they take or do not take because of errors or omissions that I made in the completion of this form.

Signature of Patient / Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_ DDS Signature: \_\_\_\_\_

**DENTAL INFORMATION** FOR THE FOLLOWING QUESTIONS, PLEASE MARK (X) YOUR RESPONSES TO THE FOLLOWING QUESTIONS.

|   | YES | NO |
|---|-----|----|
| Do your gums bleed when you brush or floss?.....  |     |    |
| Are your teeth sensitive to cold, hot, sweets, or pressure?.....  |     |    |
| Does food or floss catch between your teeth?.....   |     |    |
| Is your mouth dry? .....  |     |    |
| Have you had any periodontal (gum) treatments?.....   |     |    |
| Have you ever had any orthodontic (braces) treatments?.....   |     |    |
| Have you had any problems associated with previous dental treatment? ( Fainting, Allergic reaction, etc.) ..... |     |    |
| If yes please explain _____   |     |    |
| Is your home water supply fluoridated?.....   |     |    |
| Do you drink bottled water or filtered water?.....  |     |    |
| If yes, how often? _____  |     |    |
| Circle One: Daily / Weekly / Occasionally   |     |    |
| Are you currently experiencing dental pain or discomfort?.....  |     |    |

**List any medications you are taking:**

|          |           |
|----------|-----------|
| 1. _____ | 8. _____  |
| 2. _____ | 9. _____  |
| 3. _____ | 10. _____ |
| 4. _____ | 11. _____ |
| 5. _____ | 12. _____ |
| 6. _____ | 13. _____ |
| 7. _____ | 14. _____ |

|   | YES | NO |
|---|-----|----|
| Do you have earaches or neck pain?.....   |     |    |
| Do you have any clicking, popping or discomfort in the jaw?.....  |     |    |
| Do you brux or grind you teeth?.....  |     |    |
| Do you have sores or ulcers in your mouth?.....   |     |    |
| Do you wear dentures or partials?.....  |     |    |
| If yes, Are they painful or loose?.....   |     |    |
| Do you participate in active recreational activities?.....  |     |    |
| Have you had a serious injury to your head or mouth?.....   |     |    |
| Date of your last dental exam: _____  |     |    |
| Date of last dental x-rays? _____   |     |    |
| Please rank the following in the order in which they would KEEP YOU FROM Having dental treatment. ( 1 - 5 ) 1 Most Important, 5 Least Important |     |    |
| FEAR of pain # _____ LACK of concern # _____ COST of treatment # _____ MISSING work time# _____   |     |    |

**Previous Dentist Name or Referring Dentist (Please circle which one)**

Name \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

**MEDICAL HEALTH HISTORY**

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems. (Check DK if you Don't Know the answer to the question)

|   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination).....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you taking, or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous or oral bisphosphonates (Aredia or zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's Disease, multiple myeloma or metastatic cancer?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, circle one: Intravenous or Oral   |                          |                          |
| Date treatment began? _____   |                          |                          |

|   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| Did / Do you participate in NA / AA ?.....              | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you use controlled substances (drugs)?.....          | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you use tobacco (smoking, snuff, chew, bidis) ?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, are you interested in stopping?.....             | <input type="checkbox"/> | <input type="checkbox"/> |
| (Circle one) VERY / SOMEWHAT / NOT INTERESTED           |                          |                          |
| Do you drink alcoholic beverages?.....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| How Often? _____  |                          |                          |

**WOMEN ONLY are you:**

|  |                          |                          |
|--|--------------------------|--------------------------|
| Pregnant? _____ Number of weeks: _____                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Taking birth control pills or hormonal replacement?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Nursing?.....  | <input type="checkbox"/> | <input type="checkbox"/> |

**Joint Replacement**, Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?.....  
 Date: \_\_\_\_\_ If yes, have you had any complications? \_\_\_\_\_

|  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| Allergies—Are you allergic to or have you had a reaction to: |                          |                          |
| To all <b>yes</b> responses, specify type of reaction        |                          |                          |
| Local anesthetics.....                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin or other antibiotics.....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates, sedatives, or sleeping pills.....              | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa drugs.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Codeine or other narcotics.....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Metals.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Latex (Rubber).....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Iodine.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Hay fever / seasonal.....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Animals.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Food.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Other.....   | <input type="checkbox"/> | <input type="checkbox"/> |