PATIENT REGISTRATION & HEALTH HISTORY

DENTISTRY Of Olde Towne

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Patient Name:_____Birthdate:_____Age:_____
Address:_____
Street (No P.O. Box numbers, please) City State Zip

Patient Social Security #:_____ Email address for contact:_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____
Employer Name and Address:_____
Referred By:_____
Former Dentist:_____ Address:_____
City State

Physician:_____ Address: _____
City State

Name of Parent/Spouse:_____ Birthdate:_____ Social Security #:_____
Parent/Spouse Address:_____
(If different from patient) Street City State Zip

No	Yes	
□	□	Are you in good health? Date of last physical exam?_____
□	□	Are you currently taking any medicine or drugs? If yes, list_____
□	□	Do you have any allergies to medicine, drugs, food (i.e. penicillin, aspirin)? If yes, list_____
□	□	Have you experienced any unfavorable reaction to any previous dental treatment? If yes, list_____
□	□	Women: Are you pregnant, is there any chance you are pregnant, or are you planning a pregnancy?

Do you have, or have you had any of the following:

- □ Rheumatic Fever
- □ Heart Problems
- □ Heart Valve Deficiency
- □ Stroke
- □ Blood Pressure Problems
- □ Diabetes (Type 1 or 2)
- □ Hypoglycemia
- □ Thyroid Problems
- □ Asthma
- □ Immune Deficiency
- □ Emphysema, COPD
- □ Bronchitis
- □ Anemia
- □ Bleeding Problems
- □ Venereal Disease
- □ Tuberculosis
- □ Kidney Problems
- □ Ulcers
- □ Glaucoma
- □ Artificial Joint
- □ Epilepsy
- □ Arthritis
- □ Radiation Therapy
- □ Psychiatric Care
- □ Fainting
- □ Hepatitis (A, B, C)
- □ Liver Disease, Jaundice
- □ Osteoporosis
- □ Take Bisphosphonates
- □ Cancer

Do you have health problems other than those listed above? If so, please list_____
_____
What is your present dental problem?_____ Date of last dental visit:_____
If you could rate your smile from 1 to 10, with 10 being the best, what rating would you give yourself?_____
Would you want to do anything to improve your smile?_____
Do you have anxiety regarding dental treatment? (circle one) none mild moderate severe

IF YOU HAVE DENTAL INSURANCE WE WILL ESTIMATE YOUR PORTION TO BE PAID AT THE TIME PROFESSIONAL SERVICES ARE RENDERED. IF THERE IS NO INSURANCE COVERAGE FOR YOUR TREATMENT, PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE AND I AGREE TO THE PAYMENT TERMS.

Signature:_____ Date:_____