Plunkett & Chaw Dental

PATIENT REGISTRATION AND HEALTH HISTORY

TODAY'S DATE _____ SOCIAL SECURITY # _____

PATIENT'S NAME _____ BIRTH DATE _____

IF CHILD, PARENT'S NAME _____

HOME ADDRESS _____
STREET CITY STATE ZIP

HOME PHONE # _____ WORK PHONE # _____ CELL PHONE # _____

EMPLOYER NAME _____ OCCUPATION _____

WORK ADDRESS _____ E-MAIL _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

SPOUSE NAME _____

SPOUSE EMPLOYER _____ WORK PHONE # _____ CELL PHONE # _____

PERSON TO CONTACT FOR EMERGENCY _____

ADDRESS _____ PHONE # _____

CLOSEST RELATIVE NOT LIVING WITH YOU _____

ADDRESS _____ PHONE # _____

DO YOU HAVE DENTAL INSURANCE? _____

INSURANCE COMPANY NAME _____

ADDRESS _____

EMPLOYEE NAME _____ SS # _____

GROUP # _____ POLICY # _____

SECONDARY INSURANCE? _____

INSURANCE COMPANY NAME _____

PHYSICIAN'S NAME _____ PHONE # _____

ADDRESS _____

ARE YOU HAVING PAIN OR DISCOMFORT AT THIS TIME? _____

DO YOU FEEL VERY NERVOUS ABOUT HAVING DENTAL TREATMENT? _____

PLEASE DO NOT WRITE BELOW THIS LINE

NOTES: _____

_____

_____

_____

_____

_____

_____

PLUNKETT & CHAW DENTAL

HEALTH HISTORY

PLEASE CIRCLE

1. For what reason have you ever been hospitalized? _____
2. Have you been under the care of a medical doctor during the past two years? ..... YES NO
3. Have you taken any medication or drugs during the past two years? ..... YES NO
   Are you now taking any medication, drugs or pills? If yes, please list _____
4. Have you ever taken Biophosphonates for osteoporosis or for chemotherapy for cancers (Fosamax, Actonel, Boniva, Aredia or Zometa or others)? ..... YES NO
5. Are you allergic or have you reacted adversely to any of the following? ..... YES NO

Aspirin	Nitrous Oxide	Valium	Local Anesthetic	Metal
Darvon	Erythromycin	Scopolamine	(Novocaine or Xylocaine)	Latex
Codeine	Tetracycline	Penicillin	Sleeping Pills	Iodine
Demerol	Percodan	Other Antibiotics	(Nembutal/Seconal)	Sulfa

6. Are you aware of being allergic to any other medications or substance? ..... YES NO
   If yes, please explain _____
7. Have you ever had or do you have at present, any of the following:

Heart Failure or Heart Trouble	YES	NO	Cosmetic Surgery	YES	NO	Use Tobacco	YES	NO
Heart Attack	YES	NO	Emphysema	YES	NO	A.I.D.S. or H.I.V.	YES	NO
Angina Pectoris	YES	NO	Cough	YES	NO	Hepatitis A (Infectious)	YES	NO
High Blood Pressure	YES	NO	Tuberculosis (TB)	YES	NO	Hepatitis B (serum)	YES	NO
Heart Murmur	YES	NO	Asthma	YES	NO	Liver Disease	YES	NO
Mitral Valve Prolapse	YES	NO	Hay Fever	YES	NO	Yellow Jaundice	YES	NO
Rheumatic Fever	YES	NO	Sinus Trouble	YES	NO	Blood Transfusion	YES	NO
Congenital Heart Lesions	YES	NO	Allergies or Hives	YES	NO	Drug Addiction	YES	NO
Scarlet Fever	YES	NO	Diabetes	YES	NO	Hemophilia	YES	NO
Artificial Heart Valve	YES	NO	Thyroid Disease	YES	NO	Venereal Disease (Syphilis, Gonorrhea)	YES	NO
Heart Pacemaker	YES	NO	X-ray or Cobalt Treatment	YES	NO	Cold Sores/Fever Blisters	YES	NO
Heart Surgery	YES	NO	Chemotherapy	YES	NO	Epilepsy or Seizures	YES	NO
Artificial Joints (Hip, Knee or Other)	YES	NO	Arthritis	YES	NO	Fainting or Dizzy Spells	YES	NO
Anemia	YES	NO	Rheumatism	YES	NO	Nervousness	YES	NO
Stroke	YES	NO	Cortisone Medicine	YES	NO	Psychiatric Treatment	YES	NO
Kidney Trouble	YES	NO	Glaucoma	YES	NO	Sickle Cell Disease	YES	NO
Ulcers	YES	NO	Pain in Jaw Joints	YES	NO	Bruise Easily	YES	NO
Sleep Apnea	YES	NO	Persistent Staff Infections	YES	NO	MRSA	YES	NO

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ..... YES NO
9. Has your medical doctor ever said you have cancer or a tumor? ..... YES NO
10. Do your ankles swell during the day? ..... YES NO
11. Do you use more than 2 pillows to sleep? ..... YES NO
12. Have you lost or gained more than 10 pounds in the past year? ..... YES NO
13. Do you ever wake up from sleep short of breath? ..... YES NO
14. Are you on a special diet? ..... YES NO
15. Do you have any disease, condition, or problem not listed? ..... YES NO

FOR WOMEN ONLY:

Are you pregnant? ❑ Yes ❑ No If yes, due date? _____ . Are you taking birth control pills? ❑ Yes ❑ No

ABOVE INFORMATION IS TRUE

Patient Signature _____ Date _____ /_____ / _____

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself of my dependents is mine, due and payable at the time services are rendered or as according to the attached insurance procedure form. I further understand that a 1% finance charge (12%) annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to _____