Restore Complete Dental
Registration and Health History

PATIENT INFORMATION			
Last Name:	First Name:	MI:	Sex: Male Female
Single Married Divorced Widowed	DOB:	SSN:	
Email Address:			
Do you have Facebook? Y/N	If yes, Facebook Address:		
Do you have Google+? Y/N	If yes, Gmail Email Address:		
Employer:	How did you hear about us?		
Cell Phone:	Work Phone:	Home Phone:	
Address:	City:	State:	Zip Code:
Reason for Visit?			
Name immediate family members who are patients here:			

EMERGENCY CONTACT			
Name:		Relationship:	
Current address:	City:	State:	Zip Code:
Phone:	Email:		

DENTAL INSURANCE		
I have dental insurance: YES NO		
Insured's Name:		Insurance Company:
Insured's Phone:	Insured's Email:	Insured's DOB:
Insured's Employer:	Group #:	Insured's SSN:
Insured's Address:		

RESPONSIBLE PARTY			
Name:		Relationship:	
Date of birth:	SSN:	Sex: Male Female	
Current address:	City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:	
Employer:	Occupation:	How Long?	

DENTAL HISTORY	
How long since you've seen a dentist?	Last complete dental exam? (date)
Name of Previous Dentist:	Location:
How do you feel about your teeth?	
If you could change anything about your teeth, what would it be?	
Please rate the following in order of importance: (1) Most Important; (2) Some Importance; (3) Least Important ( ) Fear of Pain; ( ) Cost of Treatment; ( ) Missing Work Time	

Are you currently having dental problems? What are they?	Y/N	Are your teeth sensitive to hot, cold, sweet, pressure?	Y/N
		Are you unhappy w/ the appearance of your teeth?	Y/N
Do you have dry mouth?	Y/N	Do you grind or clench your teeth?	Y/N
Do you wear dentures (partial / full)?	Y/N	Do you have headaches, earaches, neck pain?	Y/N
Are you happy with your dentures?	Y/N	Have you worn braces on your teeth?	Y/N
Are you interested in permanent replacements?	Y/N	Do you have discolored teeth?	Y/N
Are you apprehensive about dental treatment?	Y/N	Would you like your smile to look better or different?	Y/N
Have you had any periodontal (gum) treatment?	Y/N	Do you regularly use dental floss?	Y/N
Do you gums bleed, or feel tender or irritated?	Y/N	Do you have slow healing mouth sores?	Y/N

Reviewed:______

HEALTH HISTORY		
I currently have a primary physician: Y/N	Physician Name:	Physician Phone #:
I currently have a pharmacy: Y/N	Pharmacy Name:	Pharmacy Phone #:

Are you currently taking any over the counter or prescribed medications? Yes or No

Please list any medications that you are currently taking and reason for taking medication.

Name of Medication	Dosage	Reason

Are you currently taking blood thinning medication? YES/NO If yes, name___________________________?

Condition		Condition	
Anemia	Y/N	Kidney Trouble or Dialysis	Y/N
Arthritis/Rheumatoid/Osteo	Y/N	Latex Sensitivity	Y/N
Asthma	Y/N	Liver Disease, including jaundice	Y/N
Biophosphonates for Osteoporosis?	Y/N	Low Blood Pressure	Y/N
Blood Disorders	Y/N	Mitral Valve Prolapse	Y/N
Cancer	Y/N	Pacemaker	Y/N
Diabetes	Y/N	Are you currently pregnant?	Y/N
Do you have sleep apnea or us C-Pap?	Y/N	Psychosis or Anxiety Disorder	Y/N
Emphysema/COPD	Y/N	Do you smoke?	Y/N
Epilepsy or Seizures	Y/N	Sore/Enlarged Lymph Nodes	Y/N
Eye, Ear, Nose or Throat Problems	Y/N	Special Needs (Autism, MR, CP, ADHD)	Y/N
Glaucoma	Y/N	Stomach or Intestinal Problem	Y/N
Have you ever taken cortisone or steroids?	Y/N	Stroke	Y/N
Hepatitis, in any form?	Y/N	Thyroid	Y/N
High Blood Pressure	Y/N	Tuberculosis	Y/N
High Cholesterol	Y/N	X-Ray Therapy (Head or Neck)	Y/N
Do you take any weight loss medication, such as phentermine or Phen-fen?	Y/N	Other?	Y/N
HIV Positive or AIDS related complex	Y/N		

Have you been hospitalized in last 5 years? Y/N
If yes, why?

Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, damaged coronary heart valves, heart murmur, artificial heart valve, Bypass Surgery, Other?) Y/N
If yes, when?

Have you had any abnormal bleeding associated with previous surgery, tooth extraction or trauma? Y/N

Have you had any joint replacement(s)? Y/N
If yes, when?

Are you allergic to OR had a reaction to any of the following: Y/N If yes, please check the appropriate ones.
Latex Local Anesthetics Penicillin/Antibiotics Aspirin Sulfa Drugs Codeine Other Narcotics?

Are you allergic to any other foods or medications? Y/N

Is there any other disease, condition, or problem not listed above that we should know about? Y/N
Please List

RESPONSIBILITY AND CONSENT STATEMENT

I give consent to any and all dental procedures, medications, or anesthetics deemed necessary by the dentist to be administered by the dentist or by her staff for diagnostic purposes or dental treatment. I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage. I also understand that the treatment estimate presented to me is only an estimate. Occasionally the need may arise to modify treatment. In such a case, I will be informed of the need for additional treatment, and its fee. I understand and agree that any past due payments shall accrue simple interest at the rate of 18%. I also agree to be responsible for all reasonable and actual collections fees if collections become necessary.

Printed Name:	Signature:	Date:

Reviewed:______