

PATIENT HEALTH REGISTRATION

Date _____

Name _____ Spouse's Name _____
 Address _____
 Home Phone _____ Business Phone _____
 Cell Phone _____ Email Address _____
 Date of Birth _____ Sex _____ Height _____ Weight _____
 Social Security No. _____ Single _____ Married _____
 Employer _____ Occupation _____
 Closest Relative _____ Phone _____
 Whom may we thank for referring you to us? _____

MEDICAL HEALTH

Name and address of physician _____
 Have you been under a physician's care during the past 2 years? For _____
 Have you been treated in a hospital in the past 2 years? For _____
 Have you ever had a major surgery? _____
 If female: Are you taking hormones or birth control? _____ Are you pregnant or nursing? _____
 Have you ever had a blood test for hepatitis? _____ Were you vaccinated? _____
 Are you now taking or have taken any prescription drugs during the past year? _____
 Please list: 1. _____ 2. _____ 3. _____
 4. _____ 5. _____ 6. _____
 Are you allergic to: Penicillin Codeine Local anesthetics Other _____

Have you had or do you now have:

	yes	no		yes	no
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valves	<input type="checkbox"/>	<input type="checkbox"/>	Organ transplant	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged cough	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart lesions	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>
Drug dependency	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>

Have you any disease, condition, or problem not previously listed? _____

DENTAL HEALTH

When was your last dental visit? _____
How often do you see your dentist? _____
Are you having any dental problems that require immediate attention? _____
Do any of the following cause tooth discomfort? Hot _____ Cold _____ Sweets _____ Chewing _____
How often do you brush your teeth? _____ Floss? _____
Do your gums bleed while cleaning? _____
Do your gums ever feel tender or swollen? _____
Have you had periodontal treatment? _____ When? _____
Do you clench or grind your teeth? _____
Can you chew on both sides of your mouth? _____ Comfortably? _____
Do you have frequent headaches? _____ Earaches? _____
Have you ever had orthodontic treatment (braces)? _____ When? _____
Do you lose fillings or break fillings? _____
Do you usually have many cavities? _____
Do you have any loose teeth? _____ Cracked or broken teeth? _____
Do you have any noticeable wear on your teeth? _____ Food traps? _____
Do you have any missing teeth? _____ Have they ever been replaced? _____
If so, how? Fixed bridge _____ Removable partial _____ Full denture _____ Dental implant _____
Are you comfortable with the replacement? _____ Please describe _____

TMJ History :

Have you ever had a problem with your TMJ's (your jaw joints)? _____
Have you ever had an injury to your jaw? _____
Do your jaw joints ever hurt or become tender when you chew or talk? _____ Or open wide? _____
Do you ever hear any clicks, pops, or grating sounds in your jaw joints? _____
Does your jaw ever get stuck, or locked or go out? _____
Do you ever have difficulty opening your jaw? _____ When does it happen? _____
Do you ever have any problems with your joints when you eat or chew? _____
Does your jaw ever feel tired or ache? _____

Aesthetics:

How do you feel about the appearance of your smile? _____
Would you like whiter teeth? _____
Have you ever had any cosmetic dentistry done to improve your appearance? _____
If yes, are you pleased with the result? _____ Please comment _____

Have you ever had an unpleasant dental experience? _____
Please add anything you feel is important: _____

Informed consent: I consent to receive special consultation and should I agree to accept professional advice, also consent to the performing of whatever dental procedure may be decided necessary or advisable in the opinion of Dr. Soria. I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full, at or before completion, unless other specific arrangements are made with the office manager. I authorize my insurance carrier to issue the dental benefits of my plan directly to this dental office. I also authorize release of any information necessary to process dental insurance.