

# PATIENT REGISTRATION AND HEALTH HISTORY

(PLEASE PRINT)

## PATIENT INFORMATION

Date \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Goes By \_\_\_\_\_  
Last Name First Name Middle Initial

Address \_\_\_\_\_ E-mail Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex M \_\_\_\_\_ F \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Occupation \_\_\_\_\_

Married \_\_\_\_\_ Widowed \_\_\_\_\_ Single \_\_\_\_\_ Minor \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_

Patient Employer/School \_\_\_\_\_ Employer Phone (\_\_\_\_) \_\_\_\_\_

Employer Address \_\_\_\_\_  
Street City State Zip

In case of emergency who should be notified? \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

How did you hear about our office? Family \_\_\_\_\_ Friend \_\_\_\_\_ Online \_\_\_\_\_ Mailing \_\_\_\_\_ Other \_\_\_\_\_

To confirm or schedule appointments, contact me via: (Please check one of the following.)

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_ Text Message \_\_\_\_\_ Other \_\_\_\_\_

## PERSON RESPONSIBLE FOR ACCOUNT / PRIMARY DENTAL INSURANCE

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Middle Initial

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc.Sec.# \_\_\_\_\_

Address (If different from patient's) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Occupation \_\_\_\_\_

Person Responsible Employed by \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_

Dental Insurance Company \_\_\_\_\_

Employee ID/Soc.Sec. Number \_\_\_\_\_ Group # \_\_\_\_\_

## SECONDARY DENTAL INSURANCE

Is patient covered by additional dental insurance? Yes \_\_\_\_\_ No \_\_\_\_\_

Relation to Patient \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Insurance Company \_\_\_\_\_ Employer \_\_\_\_\_

Employee \_\_\_\_\_ Birthdate \_\_\_\_\_

Employee ID/Soc. Sec. Number \_\_\_\_\_ Group # \_\_\_\_\_

Please Complete Both Sides

## DENTAL HISTORY

Are you having pain or discomfort at this time?  Yes  No

Date of last dental visit \_\_\_\_\_

**Check (✓) to indicate if you have had any of the following:**

- Bad Breath
- Bleeding Gums
- Blisters on lips or mouth
- Burning sensation on tongue
- Chew on one side of mouth
- Cigarette, pipe, or cigar smoking
- How many packs \_\_\_\_\_

- Clicking or popping jaw
- Dry mouth
- Fingernail biting
- Food collection between the teeth
- Grinding teeth
- Gums swollen or tender
- Jaw pain or tiredness
- Lip or cheek biting
- Loose teeth or broken fillings
- Mouth breathing
- Mouth pain, brushing
- Oral piercings

- Orthodontic treatment
- Pain around ear
- Periodontal treatment
- Sensitivity to cold
- Sensitivity to heat
- Sensitivity to sweets
- Sensitivity when biting
- Sensitivity when brushing
- Sores or growths in your mouth
- How often do you floss? \_\_\_\_\_
- How often do you brush? \_\_\_\_\_
- Have you ever missed a dental appointment due to anxiety?  Yes  No

## HEALTH HISTORY

Have you been under the care of a medical doctor during the past 2 years?  Yes  No

Physician's name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Any Recent Hospitalization?  Yes  No Reason \_\_\_\_\_

Are you currently taking any medication?  Yes  No If Yes, please list \_\_\_\_\_

Are there any medications that you should be taking that you are not taking?  Yes  No

If Yes, please list \_\_\_\_\_

Do you have any Allergies?  Yes  No If Yes, please list \_\_\_\_\_

**Check (✓) to indicate if you have had any of the following:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> ADHD  | <input type="checkbox"/> Eating Disorder          | <input type="checkbox"/> Mitral Valve Prolapse                  |
| <input type="checkbox"/> Anemia  | <input type="checkbox"/> Emphysema                | <input type="checkbox"/> Nervousness                            |
| <input type="checkbox"/> Angina Pectoris                                   | <input type="checkbox"/> Epilepsy or Seizures     | <input type="checkbox"/> Persistent Cough                       |
| <input type="checkbox"/> AIDS  | <input type="checkbox"/> Fainting or Dizzy Spells | <input type="checkbox"/> Psychiatric Treatment                  |
| <input type="checkbox"/> Allergies or Hives                                | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Rheumatic Fever                        |
| <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Hay Fever                | <input type="checkbox"/> Rheumatism                             |
| <input type="checkbox"/> Artificial Heart Valve                            | <input type="checkbox"/> Heart Disease or Attack  | <input type="checkbox"/> Scarlet Fever                          |
| <input type="checkbox"/> Artificial Joints (Hip, Knee)                     | <input type="checkbox"/> Heart Failure            | <input type="checkbox"/> Sickle Cell Disease                    |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Sinus Trouble                          |
| <input type="checkbox"/> Blood Transfusion                                 | <input type="checkbox"/> Heart Pacemaker          | <input type="checkbox"/> Stroke                                 |
| <input type="checkbox"/> Bruise Easily                                     | <input type="checkbox"/> Heart Surgery            | <input type="checkbox"/> Substance Abuse                        |
| <input type="checkbox"/> Chemotherapy (Cancer, Leukemia)                   | <input type="checkbox"/> Hemophilia               | <input type="checkbox"/> Swelling of Feet or Ankles             |
| <input type="checkbox"/> Cobalt or Radiation Treatment                     | <input type="checkbox"/> Hepatitis A (infectious) | <input type="checkbox"/> Thyroid Disease                        |
| <input type="checkbox"/> Cold Sores (fever blisters)                       | <input type="checkbox"/> Hepatitis B (serum)      | <input type="checkbox"/> Tuberculosis (TB)                      |
| <input type="checkbox"/> Congenital Heart Lesions                          | <input type="checkbox"/> Hepatitis C              | <input type="checkbox"/> Ulcers                                 |
| <input type="checkbox"/> Cortisone Medicine                                | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Venereal Disease (Syphilis, Gonorrhea) |
| <input type="checkbox"/> Cosmetic Surgery                                  | <input type="checkbox"/> Kidney Trouble           | <input type="checkbox"/> Yellow Jaundice                        |
| <input type="checkbox"/> Diabetes <input type="checkbox"/> Diet Controlled | <input type="checkbox"/> Liver Disease            |   |

Do you have any disease, condition or problem not listed?  Yes  No Please list \_\_\_\_\_

(Women) Are you pregnant?  Yes  no If yes, what month? \_\_\_\_\_ Are you taking birth control pills  Yes  No

## AUTHORIZATION & CONSENT

The undersigned hereby authorizes Doctor Stoffregen to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate. I also authorize Doctor Stoffregen to perform any and all forms of treatment, medication and therapy that may be indicated and further authorize and consent that Doctor Stoffregen choose and employ such assistance as deemed 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 or my dependent(s) is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 1/2% finance charge (18% 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.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print name of Patient, Parent, Guardian or Representative

\_\_\_\_\_  
Relationship to Patient

***Payment is due at time of treatment unless prior arrangements have been approved***