



# PATIENT REGISTRATION & HEALTH HISTORY FORM

Date: \_\_\_\_\_

## PATIENT INFORMATION

First Name: \_\_\_\_\_ M: \_\_\_\_\_ Is the patient a student? Full Time  Part Time   
 Last Name: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Preferred Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Employer Address: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Gender: \_\_\_\_\_ Is the patient a minor? Yes  Spouse's Name: \_\_\_\_\_  
 Relationship Status: Single  Partnered  Married  Date of Birth: \_\_\_\_\_  
    Divorced  Widowed  **How did you hear about us?:** \_\_\_\_\_

## DENTAL INSURANCE

Who is responsible for this account? \_\_\_\_\_  
 Relationship to patient: \_\_\_\_\_  
 Insurance Co: \_\_\_\_\_  
 Group #: \_\_\_\_\_  
 Subscriber ID/SSN: \_\_\_\_\_  
 Is patient covered by additional insurance? Yes  No   
 Subscriber's Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Relationship to patient: \_\_\_\_\_  
 Insurance Co: \_\_\_\_\_  
 Group #: \_\_\_\_\_  
 Subscriber ID/SSN: \_\_\_\_\_

**ASSIGNMENT AND RELEASE.** I certify that I, and/or my dependents have insurance coverage with \_\_\_\_\_ and assign directly to Troutdale Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above name dental practice may use my health care information and may disclose such information to the above named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_

Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_

Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_

Date
Relationship to Patient

## CONTACT INFORMATION \*REQUIRED INFORMATION\*

\*Cell Phone (\_\_\_\_\_) \_\_\_\_\_ Is it okay to send text messages for appointment confirmations and reminders? Yes  No   
 \*Email Address: \_\_\_\_\_ This is used for appointment reminders/confirmations. This is never used for spam or given out to anyone else.  
 Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_ Best time and place to reach you: \_\_\_\_\_  
**Emergency Contact:** Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

## DENTAL HISTORY

Reason for today's visit: \_\_\_\_\_

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

Date of last dental X-rays: \_\_\_\_\_

	Yes	No
Do you have bleeding gums?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use any form of tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dry mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Does food collect between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Any loose teeth or fillings?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any jaw pain?	<input type="checkbox"/>	<input type="checkbox"/>

**SMILE EVALUATION**

	Yes	No
Would you like your teeth to be straighter?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like your teeth to be whiter?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed any wear or chipping of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>

If there is anything you could change about your teeth, what would it be?  
\_\_\_\_\_

**SLEEP HEALTH**

	Yes	No
Do you snore?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wakeup not feeling refreshed?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wakeup in the morning with headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Is it hard to stay awake during the day?	<input type="checkbox"/>	<input type="checkbox"/>

## HEALTH HISTORY

Yes No

- AIDS/HIV
- Anemia
- Anxiety
- Arthritis, Rheumatism
- Asthma
- Back Problems
- Blood Disease
- Cancer
- Chemical Dependency
- Chemotherapy
- Circulatory Problems
- Cortisone Treatments
- Diabetes
- Emphysema
- Epilepsy
- Fainting or dizziness
- Glaucoma
- Headaches
- Hepatitis Type \_\_\_\_\_

Yes No

- Herpes
- High Blood Pressure
- Jaundice
- Kidney Disease
- Liver Disease
- Low Blood Pressure
- Nervous System Problems
- Psychiatric Care
- Radiation Treatment
- Respiratory Disease
- Shortness of Breath
- Sinus Trouble
- Swollen Neck Glands
- Thyroid Problems
- Tonsillitis
- Tuberculosis
- Tumor or growths on head
- Ulcer

Yes No

- Artificial Heart Valves
- Artificial Joints
- Abnormal Bleeding After Surgery
- Congenital Heart Lesions
- Heart Murmur
- Mitral Valve Prolapse
- Pacemaker
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Premedication needed for dental visits?
- Are You Pregnant?

Other Heart Problems: \_\_\_\_\_

\_\_\_\_\_

Other Medical Conditions: \_\_\_\_\_

\_\_\_\_\_

## MEDICATIONS

Please list any medications that you are currently taking:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician Name: \_\_\_\_\_

Physician Location: \_\_\_\_\_

Physician Phone: \_\_\_\_\_

## ALLERGIES

Yes No

- Penicillin or other antibiotics
- Aspirin
- Codeine or other narcotics
- Iodine
- Latex
- Local Anesthetic
- Sulfa Drugs
- Reaction to metals

Other/Details: \_\_\_\_\_

\_\_\_\_\_

The undersigned hereby authorizes the doctors and staff at Troutdale Dental to perform dental exams, take x-rays, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize the doctors at Troutdale Dental to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize the use of anesthetics and understand that use of anesthetics embodies a certain risk.

**I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE**

Sign here: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor: \_\_\_\_\_ Date: \_\_\_\_\_