ARTHUR STREET DENTAL OFFICE

DENTAL REGISTRATION AND HEALTH HISTORY FORM

Name _____ Date of Birth _____ Marital Status _____

Address _____ City _____ Postal Code _____

Telephone: Home _____ Cellular _____ Work _____

Employer _____ Present position _____ How long held _____

Name of Spouse _____

Spouse employed by _____ Spouse business phone number _____

Emergency contact: name & phone number _____ Relationship _____

Dental insurance company _____

Policy/Certificate # _____ Group # _____

Employer _____ Who will pay for this account _____

MEDICAL HISTORY

Physician's name _____ Date of last medical exam _____

What medical conditions, if any, are you currently being treated for? _____

Please list the medications you are taking: _____

Do you have any allergies? If yes, please specify: _____

Have you been hospitalized in the last 3 years? If so,what for? _____

Are you pregnant? _____ Do you smoke or chew tobacco? _____

Do you currently have or in the past have you had any of the following?

- ☐ heart problems
- ☐ diabetes
- ☐ mitral valve prolapsed
- ☐ hepatitis
- ☐ history of stroke/heart attack
- ☐ thyroid problem
- ☐ history of heart surgery
- ☐ liver disease
- ☐ artificial heart valve
- ☐ gall bladder disease
- ☐ angina
- ☐ kidney disease
- ☐ crohn's disease/colitis/stomach ulcer
- ☐ anemia
- ☐ HIV/AIDS
- ☐ excessive bleeding
- ☐ tuberculosis
- ☐ cancer
- ☐ rheumatic fever
- ☐ radiation/chemotherapy treatments
- ☐ malignant hypothermia
- ☐ organ transplants
- ☐ epilepsy/seizures
- ☐ arthritis
- ☐ migraines
- ☐ joint replacement
- ☐ psychiatric care
- ☐ osteoporosis
- ☐ asthma
- ☐ sinus trouble
- ☐ cortisone/steroid therapy

Is there any other medical concern not listed above which may affect your dental treatment? _____

I certify that the information above is accurate and complete.

Signature _____ Date _____

DENTAL HISTORY

Date _____

When was your last dental visit? _____

Do you require antibiotic pre-med prior to dental treatment? ❑ No ❑ Yes

If yes, please specify for what medical condition? _____

How do you feel about your teeth? Any concerns? What are your expectations? Are you happy with your smile?

_____

_____

_____

_____

Are you anxious about dental treatment? No _____ Yes _____ (rate from scale of 1 to 10)

Any unpleasant dental experience? _____

Any previous adverse reaction to local anesthetic? E.g. fainting, light-headed _____

Have you ever had trouble getting frozen? _____

How many times do you brush each day? _____ ❑ Manual ❑ Electric

How often do you floss? _____