CALIAN DENTAL GROUP

HEALTH HISTORY & REGISTRATION

Patient _____ Date _____

Home Phone _____ Patient's Birthdate _____ Social Security# _____

Patient is: Single Married Widowed Separated Divorced

if patient is minor: Responsible Party _____ Social Security# _____

Address _____ City _____ State _____ Zip _____

Email Address _____ Cell Phone# _____

Employer _____ How Long _____ Bus. Phone _____

Employer Address _____ City _____

Spouse _____

Spouse's Employer _____ Bus. Phone _____

Employer Address _____ City _____ State _____ Zip _____

In case of emergency call _____ Relationship _____

Phone _____ Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION:

Insured's Name _____

Insured's Birthdate _____

Insurance Co. _____

Insurance Co. Address _____

Policy# _____ Plan/ID# _____

SECONDARY INSURANCE INFORMATION (if applicable):

Insured's Name _____

Insured's Birthdate _____

Insurance Co. _____

Insurance Co. Address _____

Policy# _____ Plan/ID# _____

Please complete the Dental and Medical History below. This information is strictly confidential and will not be released to anyone without your knowledge and approval.

DENTAL HISTORY

When were you last seen by a dentist ___Yrs ___ Mos ___Wks

Reason for visit? _____

When was your last complete dental exam? _____

How long has it been since you've had dental x-rays? ___Yrs ___ Mos ___Wks

Are you having problems now? ○ Yes ○ No

If yes, explain _____

How would you rate your current dental health? ○ Poor ○ Fair

Do you wear dentures? ○ Yes ○ No

If yes, are you dissatisfied with your dentures? ○ Yes ○ No

If yes, explain _____

How would you rate your previous dental experiences?

○ Unpleasant ○ Bearable ○ Comfortable

Are you apprehensive or fearful of dental treatment? ○ Yes ○ No

Have you ever received periodontal (gum) treatment? ○ Yes ○ No

Do your gums bleed or feel tender or irritated? ○ Yes ○ No

Are your teeth sensitive to? Hot Cold ○ Sweets ○ Pressure ○

In general, how do you feel about the apprearance of your teeth?

○ Unhappy ○ Satisfied ○ If unhappy, explain

Are you aware of grinding or clenching your teeth? ○ Yes ○ No

Frequently experience headaches, earaches or neck pains? ○ Yes ○ No

Have you worn braces on your teeth? ○ Yes ○ No

Have you ever had problems with teeth/fillings breaking? ○ Yes ○ No

Do you brush your teeth regularly? ○ Yes ○ No

Do you floss your teeth regularly? ○ Yes ○ No

Do you have concerns about bad breath? ○ Yes ○ No

In general, how do you feel about your teeth? _____

Name of former dentsit _____

City _____ State _____

How did you hear about our office? _____

MEDICAL HISTORY

Are you under a physician's care now? ○ Yes ○ No

Are you currently taking any medication? ○ Yes ○ No

If yes, what _____

Check any of the following that you may have at present.

- Aids ☐
- A.R.C. ☐
- Allergies or Hives ☐
- Anemia ☐
- Angina Pectoris ☐
- Arthitis ☐
- Asthma ☐
- Blood Tranfusion ☐
- Bruise Easily ☐
- Cancer ☐
- Chemotherapy ☐
- Congenital Heart Lesions ☐
- Cortisone Medicine ☐
- Cosmetic Surgery ☐
- Diabetes ☐
- Drug Addiction ☐
- Emphysema ☐
- Epilepsy or Seizures ☐
- Fainting or Dizzy Spells ☐
- Fever Blisters ☐
- Glaucoma ☐
- Hay Fever ☐
- Heart Disease or Attack ☐
- Heart Failure ☐
- Heart Murmur ☐
- Heart Pacemaker
- Heart Surgery ☐
- Hemophilia ☐
- Hepatitis A (infectious) ☐
- Hepatitis B Serum ☐
- High Blood Pressure ☐
- Kidney Trouble ☐
- Liver Disease ☐
- Nervousness ☐
- Night Sweats, Fever ☐
- Pain Jaw Joints ☐
- Pigment Lesion on Mouth or Body ☐
- Pneumocystitis ☐
- Pregnancy ☐
- Psychiatric Treatment ☐
- Rheumatic Fever ☐
- Rheumatism ☐
- Scarlet Fever ☐
- Sickle Cell Disease ☐
- Sinus Trouble ☐
- Stroke ☐
- Thyroid Disease ☐
- Tuberculosis ☐
- Ulcers
- Unexplained Weight Loss (eating disorder) ☐
- Veneral Disease (syphilis, gonorrhea etc) ☐
- Xray or Cobalt Treatment
- Yellow Jaundice ☐

Are you allergic or have you reacted adversely to any of the following medications?

- Asprin ☐
- Codeine ☐
- Darvon ☐
- Erthromycin ☐
- Local Anesthetic ☐
- Nitrous Oxide ☐
- Penicillin ☐
- Percodan ☐
- Valium ☐

Are you aware of being allergic to any other medications or substances?

If yes, please list _____

Family Physician _____

Phone _____

Specifiy any other dental or medical information that you feel I should know about

_____

Patient Signature _____

NOTE: You will have an opportunity to sign this form during your next visit