REGISTRATION FORM / MEDICAL-DENTAL HISTORY

PATIENT REGISTRATION FOR: ______________________________

Residence Address	
Telephone	Referred By
Other Family Members in the Practice	Preferred Time for Appointments
SSN - -	DOB / /
Marital Status S M D W	Spouse's Name
If Minor, Name of Guardian	Address & Telephone
Person Responsible for Fee (if other than patient)	Relationship to Patient
Billing Address (if different from above)	
Occupation	Will you receive calls at work? ☐ Yes ☐ No
Employer's Name & Telephone	
EMERGENCY NOTIFICATION Name & Telephone	

INSURANCE INFORMATION

	Primary Carrier	Secondary Carrier
Name of Insurance Company	____________	____________
Address	____________	____________
Telephone	____________	____________
Subscriber's Name/ Relationship to Patient	______ / ______	______ / ______
Name of Group Policyholder or Union	____________	____________
Group Policy # / Individual Policy #	______ / ______	______ / ______
Effective Date / Time Limit for Claims	______ / ______	______ / ______
Pre Estimate Required	☐ Yes ☐ No	☐ Yes ☐ No
Method of Payment	☐ UCR ☐ Schedule of Payments ☐ Other	☐ UCR ☐ Schedule of Payments ☐ Other
Coinsurance	Company ______ % Patient ______ %	Company ______ % Patient ______ %
Deductible	☐ Yes ☐ No ☐ Individual ☐ Family ☐ Annual $ ______ ☐ Lifetime $ ______	☐ Yes ☐ No ☐ Individual ☐ Family ☐ Annual $ ______ ☐ Lifetime $ ______
Plan Covers Orthodontics	☐ Yes ☐ No	☐ Yes ☐ No
Other	____________	____________

If credit card payment is accepted: Name of Card ______________________________

Card # ______________________________ Expiration Date ____________

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THE REDWOODS GROUP DENTAL RECORD-KEEPING SYSTEM

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REGISTRATION FORM / MEDICAL-DENTAL HISTORY page 2

Medical History

INSTRUCTIONS

"I understand that honest answers to the questions stated below are important to the provision of my dental care, and that I will answer them to the best of my ability. I have been informed that if I am uncertain about the question or how the question related to my health status, I must discuss the problem with the doctor or a member of the office staff. I understand that all questions must be answered. I have been assured that the information I provide will not be released without my express permission."

Patient's Initials__________ Dentist's Initials ___________

To receive treatment in this office you must answer all questions on this history form.

The questions asked relate directly to the safe and effective treatment you are to receive in the office – to the best of your ability honest answers must be given.

If you are unsure of the question, unsure of your answer, or whether the question relates to your medical condition, you are to discuss the matter with the doctor.

Some of the questions may not relate to you or your medical condition; in that event you are to write "N/A" (not applicable) in the space provided.

All questions must be answered and written in ink.

To properly evaluate your current health status it may be necessary for the dentist to contact your physician. Included on this form is "Permission to Release Information." You are asked to sign it in the presence of a member of the office staff.

ALL INFORMATION YOU SUPPLY TO THE OFFICE ON THIS FORM, AND THE SUBSEQUENT INTERVIEW BY THE DENTIST AND INFORMATION RECEIVED FROM YOUR PHYSICIAN OR ANY OTHER SOURCE, WILL BE HELD IN THE STRICTEST CONFIDENCE, AND WILL NOT BE DISCLOSED WITHOUT YOUR EXPRESS AND WRITTEN PERMISSION.

1. Name, address & phone # of your physician ____
2. Date of last visit to your doctor _________ Purpose of visit ________________________________
3. Do you suffer from any disability?_______ If yes, describe ________________________________

   ____
4. Have you ever, or do you now take illegal drugs?_______ If yes, what drugs, and when taken? ______________

   ____

   Note: There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal.
5. Do you have AIDS, or are you HIV-positive? ________ If yes, describe and provide current status. ______________

   ____
6. Do you now have, or have you ever had a venereal disease? ______ If yes, describe.____________________
7. Have you ever had, or do you now have hepatitis? _____ If yes, describe. __________________________
8. For females: Are you pregnant?________ If yes, when are you due? ___________________________
9. For females: Are you taking birth control pills? _________ *Note: There are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills.*
10. Are you taking any drugs or medications?_______ If yes, list and describe amounts and purpose. ______________

    ____

    Note: There are many drugs and medications when mixed with other drugs and/or medications may cause complications, some of which may result in dangerous health problems. Information about your current use of drugs and medication is essential.
11. Have you ever had an allergic reaction to medication?_______ If yes, describe.______________________
12. Have you lost weight recently? _________ If yes, describe. ______________________________

Have You Ever Had Or Been Treated For:

13. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease? ____________________

    ____
14. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats? ____________________

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Medical History [continued]

15. Stomach or intestinal disease? ______________________________

16. Abnormal blood pressure, excessive bleeding, or anemia? ______________________________

17. Breathing problems, asthma, tuberculosis, or hay fever? ______________________________
____

18. Cancer, X-ray treatments, or chemotherapy? ______________________________
____

19. Diabetes? ______________________________

20. Kidney problems or renal dialysis? ______________________________

21. A stroke, convulsions, or fainting spells? ______________________________

22. Tumors or growths? ______________________________

23. Arthritis or rheumatism? ______________________________

24. Have you ever had a major operation? ____________ Is yes, describe. ______________________________
____

25. Have you ever had a serious injury to your head or neck? ____________ If yes, describe. ______________________________
____

26. Are you on a special diet? __________ If yes, for what reason and describe. ______________________________

27. Do you smoke? ____________ If yes, describe type and quantity. ______________________________

28. Have you consulted or been treated by a psychiatrist, psychologist, or counselor? __________ If yes, when and describe.
____

29. Do you consume any alcoholic beverages? If yes, how much and how often? ______________________________

30. Are there any other problems about your health of which you are aware? ______________________________
____
____

31. For children under 10 years old: Was the child born by Cesarean Section? ______________________________

32. Females: Are you currently taking any bisphosphonate medication? ______________________________

33. Have you had any prosthetic joint replacement? ______________________________

Dental History

1. Name of previous dentist ______________________________ Date of your last visit ____________

2. Reason for your last visit (or series of visits) ______________________________

3. Do you have any of your X-rays or dental records? ______________________________

4. Chief dental complaint if any? ______________________________

In respect to any previous dental treatment have you:

5. Ever fainted? ______________________________

6. Had an allergic reaction? ______________________________

7. Had abnormal bleeding? ______________________________

8. Any other complications during or following dental treatment? ____________ If yes, describe. ____________
____

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Dental History [continued]

9. Do your gums bleed on brushing or eating? ____________________
10. Does food catch between your teeth? ____________________
11. Have your teeth shifted, are there spaces between your teeth now where there were none, are your teeth flaring, or are some of your teeth becoming loose? ____________________
12. Are any of your teeth sensitive to heat, cold, or pressure? ____________________
13. Do you grind your teeth or clench your jaws? ____________________
14. Do you have pain or clicking in the jaw joint in front of your ear? ____________________
    ____
15. Have your jaw muscles ever been sore? __________ If yes, describe. ____________________
    ____
16. Are there any sores or growths in your mouth? ____________________
    ____
17. Do any of your teeth ache? ____________________
18. Do you have any other dental complaint? ____________________
    ____

To the best of my knowledge, the foregoing questions have been accurately answered.

NOTE: A change in your health status should be reported to the office immediately.

"I understand that should there be a change in my health during my dental treatment, I am to inform the dentist at the earliest possible time."

Patient's Initials__________ Dentist's Initials__________

Permission To Release Health Information

I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payers, and/or health practitioners.

Person completing the form: ____________________ Signature ____________________

Witness ____________________ Print Name ____________________

If other than patient, indicate relationship ____________________ Date ____/____/____

Dentist's History Review & Significant Findings ____________________

____

____

____

____

____

____

____

____

____

Signature Dr. ____________________ Date ____/____/____

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