PATIENT REGISTRATION & HEALTH HISTORY FORM

Date: _____

PATIENT INFORMATION

First Name: _____ M: _____

Last Name: _____

Preferred Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____

Gender: _____ Is the patient a minor? Yes ☐

Relationship Status: Single ☐ Partnered ☐ Married ☐ Divorced ☐ Widowed ☐

Is the patient a student? Full Time ☐ Part Time ☐

Employer: _____

Phone: _____

Occupation: _____

Employer Address: _____

_____

Spouse's Name: _____

Date of Birth: _____

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 Roots 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?	☐	☐
Do you use any form of tobacco?	☐	☐
Do you have dry mouth?	☐	☐
Does food collect between your teeth?	☐	☐
Do you grind your teeth?	☐	☐
Any loose teeth or fillings?	☐	☐
Do you have any jaw pain?	☐	☐

SMILE EVALUATION

	Yes	No
Would you like your teeth to be straighter?	☐	☐
Would you like your teeth to be whiter?	☐	☐
Have you noticed any wear or chipping of your teeth?	☐	☐

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

_____

SLEEP HEALTH

	Yes	No
Do you snore?	☐	☐
Do you wakeup not feeling refreshed?	☐	☐
Do you wakeup in the morning with headaches?	☐	☐
Is it hard to stay awake during the day?	☐	☐

HEALTH HISTORY

Yes	No		Yes	No		Yes	No	
☐	☐	AIDS/HIV	☐	☐	Herpes	☐	☐	Artificial Heart Valves
☐	☐	Anemia	☐	☐	High Blood Pressure	☐	☐	Artificial Joints
☐	☐	Anxiety	☐	☐	Jaundice	☐	☐	Abnormal Bleeding After Surgery
☐	☐	Arthritis, Rheumatism	☐	☐	Kidney Disease	☐	☐	Congenital Heart Lesions
☐	☐	Asthma	☐	☐	Liver Disease	☐	☐	Heart Murmur
☐	☐	Back Problems	☐	☐	Low Blood Pressure	☐	☐	Mitral Valve Prolapse
☐	☐	Blood Disease	☐	☐	Nervous System Problems	☐	☐	Pacemaker
☐	☐	Cancer	☐	☐	Psychiatric Care	☐	☐	Rheumatic Fever
☐	☐	Chemical Dependency	☐	☐	Radiation Treatment	☐	☐	Scarlet Fever
☐	☐	Chemotherapy	☐	☐	Respiratory Disease	☐	☐	Stroke
☐	☐	Circulatory Problems	☐	☐	Shortness of Breath	☐	☐	Premedication needed for dental visits?
☐	☐	Cortisone Treatments	☐	☐	Sinus Trouble	☐	☐	Are You Pregnant?
☐	☐	Diabetes	☐	☐	Swollen Neck Glands			
☐	☐	Emphysema	☐	☐	Thyroid Problems			
☐	☐	Epilepsy	☐	☐	Tonsillitis			
☐	☐	Fainting or dizziness	☐	☐	Tuberculosis			
☐	☐	Glaucoma	☐	☐	Tumor or growths on head			
☐	☐	Headaches	☐	☐	Ulcer			
☐	☐	Hepatitis Type _____						

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 Roots 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 Roots 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: _____