Registration and Health History

Today's Date: _______________

Patients Name: ____ Preferred Name: __________________________
(Last First Middle Initial)

Address: ____ City: ____________________ State: ________ Zip: ________

Sex: M F Age: ______ Birth date: ___________ SS# ___________________ Single Married Widow Separated Divorced

Home Number: ________________________ Cell Number: ________________________ Work Number: ________________________

Occupation: ____ Employer: ____

Employers Address: ____ City: _________________________State:___________

If Student, name of School / College: ____ City: __________State: ______ PT or FT

Whom may we thank or how were you referred to our office: ____

If the person responsible for this patients account is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section titled "Insurance Information"

Name of responsible party: ____ Relationship to Patient: __________________

Address: ____ City: ____________________ State: ________ Zip: ________

Sex: M F Age: ______ Birth date: ___________ SS# ___________________ Single Married Widow Separated Divorced

Home Number: ________________________ Cell Number: ________________________ Work Number: ________________________

Occupation: ____ Employer: ____

Employers Address: ____ City: _________________________State:___________

Insurance Information

Policy Holders Name: ____ Relationship to Patient: ___________________________

SS #: ___________________________ Birth date: _________________________

Name of Employer: ____ Insurance Company: ______________________________

Member ID Number: ______________________________________ Group Number: ____

Secondary Insurance

Policy Holders Name: ____ Relationship to Patient: ___________________________

SS #: ___________________________ Birth date: _________________________

Name of Employer: ____ Insurance Company: ______________________________

Member ID Number: ______________________________________ Group Number: ____

Allergies

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Metals
- ☐ Other: __________

Medications

Please list the medications you are currently taking:

____

____

Pharmacy: ______________________________________

Sunnybrook dental

Dental History

Reason for today's visit: ____

Former Dentist: ____ City / State: ____

Date of last Dental Visit: ____ Date of last dental x-rays: __________________________________

Please check the box if you have had any of the following:

Bad Breath (Halitosis)	☐	Foreign Objects	☐	Pain around ear	☐
Bleeding Gums	☐	Grinding Teeth	☐	Periodontal Treatment	☐
Blisters on the lips or mouth	☐	Gums swollen or tender	☐	Sensitivity to Cold	☐
Burning sensation on tongue	☐	Jaw pain or tiredness	☐	Sensitivity to Heat	☐
Chew on one side of mouth	☐	Lip or cheek biting	☐	Sensitivity to Sweets	☐
Clicking or Popping Jaw	☐	Loose teeth or broken fillings	☐	Sensitivity when biting	☐
Dry Mouth	☐	Mouth breathing	☐	Sores or growths in your mouth	☐
Fingernail Biting	☐	Mouth pain, brushing	☐	Use of tobacco	☐
Food collection between teeth	☐	Orthodontic treatment	☐		

Have you ever had difficult extractions in the past? ☐Yes ☐No
Have you ever had prolonged bleeding following extractions? ☐Yes ☐No
Do you have a history of trauma to your jaw? ☐Yes ☐No
Have you ever been diagnosed with TMJ/TMD? ☐Yes ☐No
Have you had your wisdom teeth removed? ☐Yes ☐No When: ________________
Have you ever had instructions in oral hygiene? ☐Yes ☐No

How often do you floss? ____________________________ How often do you brush? ____________________________

Medical History

Please check the box if you have had any of the following:

AIDS/HIV Positive/ARC	☐	Circulatory Problems	☐	High Blood Pressure	☐	Special Diet	☐
Anemia	☐	Cold Sores	☐	Jaundice	☐	*Steroid Treatment	☐
Angina Pectoris	☐	*Congenital Heart Problems	☐	Kidney Disease	☐	Stroke	☐
*Any type of Implant	☐	Cortisone Treatments	☐	Liver Disease	☐	Swollen Feet or Ankles	☐
*Any type of Transplant	☐	Cough, persistent or bloody	☐	Low Blood Pressure	☐	Swollen Neck Glands	☐
Arthritis/Rheumatism	☐	Dentures or Partials	☐	Mental Retardation	☐	Thyroid Problems	☐
Artificial Heart Valves	☐	Diabetes	☐	*Mitral Valve Prolapse	☐	Tonsillitis	☐
*Artificial Joints	☐	Emphysema	☐	Nervous Problem	☐	Tuberculosis (TB)	☐
Asthma	☐	Epilepsy or Seizures	☐	Pacemaker	☐	Tumor or growth on head or neck	☐
Back Problems	☐	Fainting or Dizziness	☐	Psychiatric Care	☐	Ulcer	☐
Birth Defects	☐	Glaucoma	☐	Radiation Treatment	☐	Venereal Disease	☐
Blood Disease	☐	Hay Fever	☐	Respiratory Disease	☐	Weight Loss (unexplained)	☐
Blood Transfusion	☐	Headaches	☐	*Rheumatic Fever	☐		
Bruise Easily	☐	*Heart Murmur	☐	Scarlet Fever	☐		
Cancer (type :___________)	☐	Heart Problems/Surgery	☐	Shortness of Breath	☐		
Chemical Dependency	☐	Hemophilia	☐	Sickle Cell Disease	☐		
Chemotherapy	☐	Hepatitis (type: __________)	☐	Sinus Trouble	☐		
Chest Pain	☐	Herpes	☐	Skin Rash or Hives	☐		

* Antibiotic pre medication may be required prior to your appointment

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluamine) and Redux (dexfenfluramine). ☐Yes ☐No

Do you wear contact lenses ☐Yes ☐No

Women:
Are you pregnant now? ☐Yes ☐No Due Date: ______________
Are you nursing? ☐Yes ☐No
Are you taking oral contraceptives? ☐Yes ☐No

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand the providing incorrect information can be dangerous to my health. I authorize Sunnybrook Dental to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Dr. Stevens all insurance benefits, if any, otherwise payable to me. I understand that my dental carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X ____ ____________________________
Signature Date