HEALTH HISTORY AND PATIENT REGISTRATION FORM
IMPLANT DENTISTRY OF MID FLORIDA

Date _____

Name _____ Please circle Mr. Mrs. Ms. Miss Dr.

Address _____ City _____ State _____ Zip _____

Previous address if less than 3 years _____ City _____ State _____ Zip _____

Home phone ( ) _____ Work phone ( ) _____ Cell phone ( ) _____

Birthdate _____ Sex _____ Age _____ Email _____

Please circle one: single, married, widowed, separated, divorced

Place of employment _____ occupation _____ How long employed _____
Address of employment _____

Social Security # _____ Insurance Contract # _____

IF MARRIED
Spouse's Name _____ Birthdate _____ Social Security # _____

Referred by: Doctor: _____ Patient: _____

Yellow pages _____ Advertisement: newspaper _____ radio _____

Nearest Neighbor or Relative's Name, Address and Phone No. _____
INSURANCE INFORMATION

Primary Insurance Coverage	Second Insurance Coverage
Insured's Name _____	Insured's Name _____
Insurance Co. _____	Insurance Co. _____
Insurance Co. Address _____	Insurance Co. Address _____
Insured's Employer _____	Insured's Employer _____
Group or Policy # _____	Group or Policy # _____
Type of Insurance Dental	Type of Insurance Dental

Name of Previous Dentist _____ Last visit _____

MEDICAL HISTORY Name of Family Physician _____ Physician Telephone _____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. These facts have a direct bearing on your dental health.

1. Are you in good health? ..... YES NO
2. Has there been any change in your general health within the year? ..... YES NO
3. My last physical examination was on _____
4. Are you now under a physicians care? ..... YES NO
   If so, for what condition are you being treated _____
5. The name and address of your physician is _____
6. Have you had any serious illness or operation? ..... YES NO
   If so, what was the illness or operation _____
7. Have you been hospitalized or had a serious illness with in the last 5 years? ..... YES NO
8. Have you had any history of Tumors, Malignancies or treatment of cancer, of any nature? ..... YES NO
9. Do you have or have you ever had any of the following:
   A. Rheumatic fever or Rheumatic heart disease? ..... YES NO
   B. Congenital heart disease? ..... YES NO
   C. Heart Murmur? ..... YES NO
   D. Allergy? ..... YES NO
   E. Asthma or hay fever? ..... YES NO
   F. Sinus Trouble? ..... YES NO
   G. Hives or skin rash? ..... YES NO

H. Fainting spells or seizures? . . . . . YES NO
I. Epilepsy? . . . . . YES NO
J. Hepatitis, Jaundice or Liver disease? . . . . . YES NO
K. Arthritis? . . . . . YES NO
L. Have you ever been tested for HIV virus . . . . . YES NO
Results _____negative _____ positive
M. Inflammatory rheumatism? . . . . . YES NO
N. Stomach Ulcers. . . . . YES NO
O. Cardiovascular disease, Heart disease:
(heart trouble, heart attack, stroke, coronary insufficiency, coronary damaged heart valves, heart murmur, artificial heart valve, Mitral valve prolapse, heart surgery, etc.). . . . . YES NO
P. Kidney Trouble? . . . . . YES NO
Q. Do you have a persistent cough or cold? . . . . . YES NO
R. Diabetes? . . . . . YES NO
Do you have to urinate more than six times a day? . . . . . YES NO
Are you thirsty much of the time? . . . . . YES NO
Does your mouth feel frequently dry? . . . . . YES NO
S. Low Blood Pressure? . . . . . YES NO
T. Tuberculosis . . . . . YES NO
U. Venereal Disease? (Syphilis, Gonorrhea, etc) . . . . . YES NO
V. Sickle Cell Disease? . . . . . YES NO
W. Other _____
X. Cancer of chemotherapy, or radiation treatment, Leukemia? . . . . . YES NO
Y. Glaucoma (open, closed angle) . . . . . YES NO
Z. Night sweats . . . . . YES NO

10. Have you had an artificial hip, knee or other replacement surgery? . . . . . YES NO
11. Have you had abnormal bleeding associated with any previous surgery, extraction or trauma? . . . . YES NO
12. Do you have any blood disorder(s)? Anemia? . . . . . YES NO
Any family history of bleeding disorders? . . . . . YES NO
13. Are you taking any medicine? . . . . . YES NO
If so, what _____
14. Do you smoke? . . . . . YES NO
15. Do you chew tobacco? . . . . . YES NO
16. Are you taking any of the following? If yes, please list name.
Antibiotic or sulfa drugs? . . . . . YES NO
Anticoagulant? . . . . . YES NO
Medicine for high blood pressure? . . . . . YES NO
Tranquilizers? . . . . . YES NO
Cortisone, steriods? . . . . . YES NO
Aspirin? . . . . . YES NO
Antihistamines? . . . . . YES NO
Insulin, tolbutamide, orinase or similar drug . . . . . YES NO
Digitalis or drugs for heart disease? . . . . . YES NO
Nitroglycerin? . . . . . YES NO
Other _____
17. Are you allergic to or have your reacted adversely to:
Local Anesthetics? . . . . . YES NO
Penicillin or other antibiotics . . . . . YES NO
Sulfa Drugs? . . . . . YES NO
Barbiturates, sedatives, or sleeping pills? . . . . . YES NO
Aspirin? . . . . . YES NO
Iodine? . . . . . YES NO
Codeine or other narcotics? . . . . . YES NO
Other _____
18. Do you have any disease, condition, or problem not listed above that you think we should know about?
19. Are you employed in a position which exposes you regularly to x-rays or any other ionizing radiation? . . YES NO
20. Are you wearing contact lenses? . . . . . YES NO

DENTAL HISTORY

1. What is your chief dental complaint?_____

_____

2. Please give a brief dental history of this problem. _____

_____

3. Are you satisfied with the appearance of your teeth? . . . . . YES NO
4. Are you able to eat and chew food satisfactorily? . . . . . YES NO
5. Are you experiencing any discomfort or pain at this time? . . . . . YES NO
6. Do you have headaches, earaches, or neck pain? . . . . . YES NO
7. Do you frequently experience sinus problems? . . . . . YES NO
8. Have you had any serious trouble associated with any previous dental treatment? . . . . . YES NO
   If yes, please explain _____

WOMEN

1. Are you pregnant? . . . . . YES NO
2. Are you taking oral contraceptives or hormonal therapy? . . . . . YES NO
3. Are you Nursing? . . . . . YES NO

Please rank the following in order of which they would keep you from having dental treatment.

#_____ FEAR of pain, surgery, injections.
#_____ FEE for treatment.
#_____ TIME off work.
#_____ RESULTS expected.
#_____ NO CONCERNS.

RESPONSIBILITY AND CONSENT STATEMENT

I hereby authorize and request the performance of dental services for myself or for:

_____

I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purposed or dental treatment.

(Such as study models, photographs, and x-rays.)

I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage. Treatment plans involving extended credit circumstances may have a credit check done on my credit rating.

_____ _____

(signature of patient) (date)