



## PACIFIC DENTAL CARE

The art of Dentistry at its best

### Dental Registration and Health History

Our goal at Pacific Dental Care is to work with you to create a healthy and attractive smile you deserve. It's all about you! Please complete this form so that we can better know how to provide you with the best and most advanced dental care in our relaxing spa setting.

#### Personal History

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex: M / F Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Please Circle One: Single Married Widowed Separated Divorced

Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

**If the person responsible for this patient's account is different from the patient, or if this patient is a minor, the responsible party must fill out the section below.**

Name of Responsible Party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex: M / F Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Please Circle One: Single Married Widowed Separated Divorced

Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

**Primary Insurance Information**

Policy Holder's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ SS#: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Group#: \_\_\_\_\_

Member/Subscriber ID#: \_\_\_\_\_

**Secondary Insurance Information**

Policy Holder's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ SS#: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Group#: \_\_\_\_\_

Member/Subscriber ID#: \_\_\_\_\_

**Answers to the following questions are for our records only and will be considered confidential.**

1. Have you or any member of your family been seen by us before? Yes No

If yes, which family member(s)? \_\_\_\_\_

2. Date of last physical examination: \_\_\_\_\_ Physician's Name: \_\_\_\_\_

3. Is there anything you would like to speak with the Doctor about in private? Yes No

4. Have you been hospitalized in the past two years? Yes No

5. Have you taken any medications or drugs in the past two years? Yes No

6. Have you ever had any excessive bleeding requiring special treatment? Yes No

7. Have you ever taken Redux or Pondimin (Fen Phen)? Yes No

**Medications**

Please list medications you are currently using (i.e., Aspirin, Coumadin, Plavix, Nicotine Patch, NSAID's, etc.):

\_\_\_\_\_

**Allergies**

Aspirin: Yes No

Local Anesthesia: Yes No

Barbiturate: Yes No

Iodine: Yes No

Codeine: Yes No

Sulfa: Yes No

Penicillin: Yes No

Erythromycin: Yes No

Latex: Yes No

Metals: Yes No

Other: \_\_\_\_\_

**Place a mark on yes or no to indicate if you have had any of the following:**

Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest Pains	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina Pectoris	<input type="checkbox"/> Yes <input type="checkbox"/> No	Birth Defects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cold Sores	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any Implants	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Transfusions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Congenital Heart	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any Transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bruise Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dentures/Partials	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis <u>A</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Persistent Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eating Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis <u>B</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis <u>C</u> / Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy/Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes Simplex	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting/Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Steroid Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke (CVA)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental Retardation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tobacco Use	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Have you ever experienced any of the following problems with your jaw?**

Clicking/Clenching/Grinding	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pain in or around ears and/or headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty opening or closing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty chewing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have history of trauma to your jaw	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been diagnosed with TMJ/TMD	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Do you have any of the problems listed below?**

Swelling / Bleeding Gums Yes No

Bad Taste (Halitosis) Yes No

Loose Teeth Yes No

**Do you have sensitivity to:**

Temperature (Hot or Cold) Yes No

Biting / Pressure Yes No

Sweet / Tart Flavors Yes No

Have you ever had any sores, lumps or growths in or near your mouth? Yes No

Have you ever had prolonged bleeding following extractions? Yes No

Does food collect between your teeth? Yes No

Have you ever needed to see a Periodontist (Gum Specialist)? Yes No

Do you now have bleeding gums or any other gum conditions? Yes No

Are you having any pain or discomfort at this time? Yes No

Do you feel nervous about having dental treatment? Yes No

Have you ever had a bad experience in a dental office? Yes No

Is there anything you dislike about your smile? Yes No

**Is there anything related to your medical and/or dental history that you have not indicated above?**

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**For Women:**

Are you taking oral contraceptives? Yes No

Are you **pregnant** now? Yes No

If yes, when is your due date? \_\_\_\_\_

Are you currently breast-feeding? Yes No

I certify that I have read and understood the above information, and that the above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information (including diagnosis and records of any treatment or examination rendered to me or my child) to third party payers and/or healthcare practitioners. I

authorize and request my insurance company to directly reimburse the dentist or dental group any benefits otherwise payable to me. I understand that my dental insurance 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 on behalf of my dependents. I consent to photographs being taken. I understand they may be used for illustration and for documentation of my treatment.

X

X

**Name of Patient**

**Signature of Patient or Guardian**

**Date**

X

**Signature of Dentist**

**Date**