

NEIBAUER DENTAL CARE

HEALTH HISTORY & REGISTRATION

DATE _____

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ Middle Initial _____ SEX: M F BIRTHDATE _____ AGE _____

Soc. Sec. # _____ If Patient is a Minor, give Parent's or Guardian's Name _____

Who May We Thank for Referring You to our Office? _____ Reason for this Visit _____

RESIDENCE Street _____ Apt # _____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ Apt # _____ City _____ State _____ Zip _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMAIL _____ Would you like to receive dental care reminders via Text Messaging? Yes ___ No ___

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle Initial _____ MARITAL STATUS _____

RESIDENCE Street _____ Apt # _____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ Apt # _____ City _____ State _____ Zip _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMAIL _____

SOCIAL SECURITY # _____ BIRTHDATE _____ DRIVER'S LICENSE # _____ RELATION TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____ PHONE _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

If you have additional dental insurance coverage, complete this for the secondary carrier.

Insured's Name _____

Insurance Co. _____ PHONE _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

It is important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY	YES	NO	MEDICAL HISTORY	YES	NO
HOW LONG SINCE you have seen a dentist?			Do you have any CURRENT HEALTH PROBLEMS?	<input type="checkbox"/>	<input type="checkbox"/>
Last COMPLETE Dental Exam, Date:			Are you under a PHYSICIAN'S CARE now? If yes for what?	<input type="checkbox"/>	<input type="checkbox"/>
Last FULL MOUTH X-RAYS, DATE: (16 Small Films or Panoramic)			Have you ever taken Fen-Phen <input type="checkbox"/> Redux <input type="checkbox"/> Coumadin <input type="checkbox"/>		
Are you having PROBLEMS now?	<input type="checkbox"/>	<input type="checkbox"/>	What MEDICATIONS are you currently taking?		
WHAT?			Do you need to premedicate?	<input type="checkbox"/>	<input type="checkbox"/>
Is your present dental health POOR?	<input type="checkbox"/>	<input type="checkbox"/>	Are you PREGNANT?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear DENTURES? (Partials or Full)	<input type="checkbox"/>	<input type="checkbox"/>	Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)	<input type="checkbox"/>	<input type="checkbox"/>
Are you UNHAPPY with your dentures?	<input type="checkbox"/>	<input type="checkbox"/>	PLEASE YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:		
Would you like to know more about PERMANENT REPLACEMENT?	<input type="checkbox"/>	<input type="checkbox"/>	YES NO	YES NO	YES NO
Are you APPREHENSIVE about dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV Pos. <input type="checkbox"/>	Fainting <input type="checkbox"/>	Psychiatric care <input type="checkbox"/>
Have you had any PERIODONTAL (GUM) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	Anaphylaxis <input type="checkbox"/>	Food allergies <input type="checkbox"/>	Rapid weight gain/loss <input type="checkbox"/>
Do your gums BLEED, or feel TENDER or IRRITATED?	<input type="checkbox"/>	<input type="checkbox"/>	Anemia <input type="checkbox"/>	Glaucoma <input type="checkbox"/>	Radiation treatment <input type="checkbox"/>
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (Rheumatism) <input type="checkbox"/>	Headaches <input type="checkbox"/>	Respiratory disease <input type="checkbox"/>
Are you UNHAPPY with the APPEARANCE of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valves <input type="checkbox"/>	Heart murmur <input type="checkbox"/>	Rheumatic/scarlet fever <input type="checkbox"/>
Are you aware of GRINDING or CLENCHING your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joints <input type="checkbox"/>	Heart problems (please describe) <input type="checkbox"/>	Shingles <input type="checkbox"/>
Do you have HEADACHES, EARACHES, or NECK PAINS?	<input type="checkbox"/>	<input type="checkbox"/>	Asthma <input type="checkbox"/>		Shortness of breath <input type="checkbox"/>
Have you worn BRACES on your teeth (ORTHODONTICS)?	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies <input type="checkbox"/>	Hemophilia (Abnormal bleeding) <input type="checkbox"/>	Skin rash <input type="checkbox"/>
Do you have DISCOLORED teeth that bother you?	<input type="checkbox"/>	<input type="checkbox"/>	Back Problems <input type="checkbox"/>	Herpes <input type="checkbox"/>	Spina Bifida <input type="checkbox"/>
Would you like your smile to LOOK BETTER or DIFFERENT?	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease <input type="checkbox"/>	Hepatitis <input type="checkbox"/>	Stroke <input type="checkbox"/>
Do you REGULARLY use DENTAL FLOSS?	<input type="checkbox"/>	<input type="checkbox"/>	Cancer <input type="checkbox"/>	High blood pressure <input type="checkbox"/>	Surgical implant <input type="checkbox"/>
			Chemical dependency <input type="checkbox"/>	Jaw pain <input type="checkbox"/>	Swelling of feet or ankles <input type="checkbox"/>
			Chemotherapy <input type="checkbox"/>	Kidney disease or malfunction <input type="checkbox"/>	Thyroid disease or malfunction <input type="checkbox"/>
			Circulatory problems <input type="checkbox"/>	Liver disease <input type="checkbox"/>	Tobacco habit <input type="checkbox"/>
			Cortisone treatments <input type="checkbox"/>	Material allergies <input type="checkbox"/>	Tonsillitis <input type="checkbox"/>
			Cough (persistent) <input type="checkbox"/>	(latex, wool, metal, chemicals) <input type="checkbox"/>	Tuberculosis <input type="checkbox"/>
			Cough up blood <input type="checkbox"/>	Mitral valve prolapse <input type="checkbox"/>	Ulcer/Colitis <input type="checkbox"/>
			Diabetes <input type="checkbox"/>	Nervous problems <input type="checkbox"/>	Veneral disease <input type="checkbox"/>
			Epilepsy <input type="checkbox"/>	Pacemaker/heart surgery <input type="checkbox"/>	Multiple Sclerosis <input type="checkbox"/>
Name of Previous Dentist?			ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?		
City: _____ State: _____			Aspirin _____	Local Anesthetic _____	Erythromycin _____
How do you feel about your teeth?			Nitrous Oxide _____	Codeine _____	Penicillin _____
Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.			Are you aware of being allergic to any other medications or substances?		
FEAR of pain # _____ LACK of concern # _____			If yes, list: _____		
COST of treatment # _____ MISSING work time # _____			Is there any other Medical or Dental information that you feel we should know about?		
			FAMILY PHYSICIAN _____	PHONE _____	E-MAIL _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

PATIENT Signature (Parent of Child) _____ Date: _____ DENTIST Signature _____