BLACKMOUNTAIN
FAMILY DENTISTRY

HEALTH HISTORY AND REGISTRATION

PATIENT

Patient Name: Last _____ First_____Middle_____Nickname_____
Address: Street _____ City_____ State _____ Zip_____
Home Phone: _____Work Phone: _____ Cell/Pager:_____
Employer:_____ Occupation:_____ E-Mail:_____
Sex: M F Birth Date:_____ Marital Status:_____
Preferred method: Contact? (Circle one) Home Phone/Work Phone/Cell/E-mail/Text
Confirm? (Circle one) Home Phone/Work Phone/Cell/E-mail/Text
Statements? (Circle one) Paper mail/E-mail at the same e-mail above or this e-mail: _____
Whom may we thank for referring you to our office? _____
Reason for today's visit: _____ Last Dental Visit:_____

EMERGENCY INFORMATION

Name: Last _____ First_____ Middle_____ Marital Status:_____
Address: Street_____ City_____ State_____ Zip_____
Home Phone:_____ Work Phone:_____ Cell/Pager:_____
Employer:_____ Occupation:_____ E-Mail:_____
Relationship to Patient:_____

DENTAL INSURANCE (PRIMARY CARRIER)

Insured's Name _____
Insurance Co._____
Insured's Employer_____
Insured's SS/ID #_____
Group _____
Insured's DOB_____

SECONDARY (IF APPLIES)

Insured's Name_____
Insurance Co._____
Insured's Employer_____
Insured's SS/ID #_____
Group_____
Insured's DOB_____

We need to know about your medical and dental history. This information is confidential. Thank you for taking the time to fill out this questionnaire.

MEDICAL HISTORY

Name of Physician: _____ Office Phone: _____ Date of Last Exam:_____

	Yes	No
1. Are you under medical treatment now?.....	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?..... If yes, please explain_____ _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?..... If yes, what medication(s) are you taking and what for? _____ _____ _____	☐	☐
4. Have you ever taken Fen-Phen/Redux?.....	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?.....	☐	☐
6. Have you taken Viagra, Revati, Cialis or Levitra in the last 24 hours?.....	☐	☐
7. Do you use tobacco?.....	☐	☐
8. Do you use controlled substances?.....	☐	☐

	Yes	No
10. Are you allergic to any of the following?		
Local Anesthetics (e.g. Novocain)……	☐	☐
Penicillin or any other Antibiotics……	☐	☐
Sulfa Drugs……	☐	☐
Barbiturates……	☐	☐
Aspirin……	☐	☐
Sedatives……	☐	☐
Iodine……	☐	☐
Any Metals (e.g. nickel, mercury, etc.)……..	☐	☐
Latex Rubber……..	☐	☐
Other (please list) _____		
11. Do you have a persistent cough or throat clearing lasting more than 3 weeks?.....	☐	☐
12. Women only:		
a) Are you pregnant?..……	☐	☐
b) Are you nursing?.....	☐	☐
c) Are you taking contraceptives?.....	☐	☐

9. Do you have or have you had any of the following?
Please mark all that apply:

☐ High Blood Pressure	☐ Heart Disease	☐ Chest Pains	☐Heart Attack	☐ Pacemaker
☐ Easily Winded	☐ Rheumatic Fever	☐Heart Murmur	☐Swollen Ankles	☐Stroke
☐Hay Fever/Allergies	☐Fainting/Seizures	☐Frequently Tired	☐Tuberculosis	☐Angina
☐Low Blood Pressure	☐Anemia	☐Radiation Therapy	☐Emphysema	☐ Asthma
☐Recent Weight Loss	☐Glaucoma	☐Convulsions	☐Cancer	☐Leukemia
☐Arthritis	☐Liver Disease	☐Diabetes	☐Heart Trouble	☐ AIDS/HIV
☐Joint Replacement/Implant	☐ Kidney Diseases	☐Hepatitis/Jaundice	☐ Thyroid Problem	☐STD's
☐Respiratory Problems	☐Stomach Troubles	☐Other_____		

DENTAL HISTORY

Name of Previous Dentist:_____

	Yes	No
1. Do your gums bleed while brushing or flossing?.....	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?.....	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?.....	☐	☐
4. Do you feel pain to any of your teeth?.....	☐	☐
5. Do you have any sores or lumps in or near your mouth?.....	☐	☐
6. Have you had any head, neck, or jaw injuries?.....	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking……	☐	☐
Pain (joint, ear, side of face)……	☐	☐
Difficulty in opening or closing……	☐	☐
Difficulty in chewing……	☐	☐

	Yes	No
8. Do you have frequent headaches?.....	☐	☐
9. Do you clench or grind your teeth?.....	☐	☐
10.Do you bite your lips or cheeks frequently?	☐	☐
11.Have you ever had any difficult extractions in the past?.....	☐	☐
12.Have you ever had any prolonged bleeding following extractions?.....	☐	☐
13.Have you had any orthodontic treatment?....	☐	☐
14.Do you wear dentures or partials?.....	☐	☐
If yes, date of placement _____		
15.Have you ever received oral hygiene instructions regarding tooth/gum care?.....	☐	☐

AUTHORIZATION AND RELEASE

The undersigned hereby authorizes the Doctor to 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 Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am ultimately responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me, if I have paid the dental fees incurred. I further understand that a finance charge of 18% (1.5% per month) will be added to the total balance on all accounts over 30 days past due. Accounts that are not paid in full within 90 days will be referred to a collection agency and a $50.00 fee will be added to the account. There may be a broken appointment fee of $50 if a 48-hour notice is not given to reschedule or cancel an appointment.

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

Patient/Guardian Signature (Consent) _____ Date _____

FOR OFFICE USE ONLY:
Blood Pressure:_____
Heart Rate:_____
Initials:_____