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REGISTRATION & HEALTH HISTORY FORM

Date: _____ SSN: _____

Patient Name: _____
Last Name First Name Middle Initial

Address: _____
Street City State Zip Code

E-Mail: _____ Sex: Male Female

Date of Birth: _____
 Married Widowed Single Minor Divorced Partnered

Home Phone: (____) _____ Work Phone: (____) _____ Ext. _____ Cell Phone: (____) _____

Spouse's Name: _____
Last Name First Name Middle Initial

Spouse's Date of Birth: _____ Spouse's SSN: _____

Who may we thank for referring you? _____

EMPLOYMENT INFORMATION

Name of Employer: _____

Employer Address: _____
Street City State Zip Code

Employer Phone Number: (____) _____

EMERGENCY INFORMATION

In case of emergency, contact: _____
Name

Home Phone: (____) _____ Work Phone: (____) _____

Relationship: _____

DENTAL HISTORY

Reason for today's visit: _____ Former Dentist: _____

Date of last dental visit: _____

How often do you brush? _____ How often do you floss? _____

DENTAL HISTORY

TMJ/BITE

- | | | |
|--------------------------------|---------------------------|--------------------------|
| Chew on one side of mouth | <input type="radio"/> Yes | <input type="radio"/> No |
| Clicking or popping of the jaw | <input type="radio"/> Yes | <input type="radio"/> No |
| Grinding teeth | <input type="radio"/> Yes | <input type="radio"/> No |
| Jaw pain or tiredness | <input type="radio"/> Yes | <input type="radio"/> No |
| Orthodontic Treatment | <input type="radio"/> Yes | <input type="radio"/> No |
| Pain around ear | <input type="radio"/> Yes | <input type="radio"/> No |

TEETH

- | | | |
|-------------------------------|---------------------------|--------------------------|
| Fingernail biting | <input type="radio"/> Yes | <input type="radio"/> No |
| Food collection between teeth | <input type="radio"/> Yes | <input type="radio"/> No |
| Loose teeth/broken fillings | <input type="radio"/> Yes | <input type="radio"/> No |
| Sensitivity to cold | <input type="radio"/> Yes | <input type="radio"/> No |
| Sensitivity to heat | <input type="radio"/> Yes | <input type="radio"/> No |
| Sensitivity to sweets | <input type="radio"/> Yes | <input type="radio"/> No |
| Sensitivity when biting | <input type="radio"/> Yes | <input type="radio"/> No |

GUMS/MOUTH

- | | | |
|--------------------------------------|---------------------------|--------------------------|
| Bad Breath | <input type="radio"/> Yes | <input type="radio"/> No |
| Bleeding Gums when brushing/flossing | <input type="radio"/> Yes | <input type="radio"/> No |
| Blisters on lips/mouth | <input type="radio"/> Yes | <input type="radio"/> No |
| Burning sensation on tongue | <input type="radio"/> Yes | <input type="radio"/> No |
| Dry mouth | <input type="radio"/> Yes | <input type="radio"/> No |
| Gums swollen or tender | <input type="radio"/> Yes | <input type="radio"/> No |
| Lip or cheek biting | <input type="radio"/> Yes | <input type="radio"/> No |
| Mouth breathing | <input type="radio"/> Yes | <input type="radio"/> No |
| Periodontal Treatment | <input type="radio"/> Yes | <input type="radio"/> No |
| Sores/growths in mouth | <input type="radio"/> Yes | <input type="radio"/> No |

TOBACCO/ALCOHOL/DRUGS

- | | | |
|--|---------------------------|--------------------------|
| Do you use any type of tobacco products? | <input type="radio"/> Yes | <input type="radio"/> No |
| Type_____ | | |
| Do you have a history of tobacco use? | <input type="radio"/> Yes | <input type="radio"/> No |
| When did you quit?_____ | | |
| Are you currently using any nicotine replacement product(s)? | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you drink any alcoholic beverages? | <input type="radio"/> Yes | <input type="radio"/> No |
| Drinks per week_____ | | |
| Do you have a history of drug use? | <input type="radio"/> Yes | <input type="radio"/> No |

MEDICAL HISTORY

<p align="center"><u>Cardiovascular</u></p> <p>Artificial Heart Valves Congenital Heart Disease Heart Attack Heart Murmur High/Low Blood Pressure Mitral Valve Prolapse Pacemaker Required to take Antibiotics before dental appointments Rheumatic Fever Stroke Swollen Ankles or Feet</p>	<p>○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No</p>	<p align="center"><u>Respiratory</u></p> <p>Asthma Bronchitis/Emphysema Chronic Cough COPD Earaches Pneumonia/Lung Infection Respiratory Disease Tuberculosis Snoring Sleep Apnea</p>	<p>○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No</p>
<p align="center"><u>Neurologic</u></p> <p>Alzheimer's Disease Chemical Dependency Depression Eating Disorder(s) Epilepsy Fainting/Dizziness Headaches Nervous Problems Parkinson's Disease Psychiatric Care Seizures</p>	<p>○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No</p>	<p align="center"><u>Endocrine/Autoimmune</u></p> <p>Diabetes Type: I/II Frequent Thirst Frequent Urination Gland Problems Thyroid Problems Lupus AIDS/HIV Cancer Skin Disease Multiple Sclerosis Scleroderma Sjogrens syndrome</p>	<p>○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No</p>
<p align="center"><u>Gastrointestinal</u></p> <p>Acid reflux Gastrointestinal Disorders Hepatitis Type ____ Jaundice Liver Problems Ulcers Vomiting</p>	<p>○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No</p>	<p align="center"><u>Gastrourinary</u></p> <p>Bladder Disease Kidney Disease Reproductive Tract Problems Sexually Transmitted Diseases Venereal Disease</p>	<p>○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No</p>
<p align="center"><u>Cancer</u></p> <p>History of Cancer Type(s): _____ Chemotherapy Radiation Surgery</p>	<p>○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No</p>	<p align="center"><u>Hematology</u></p> <p>Anemia Blood Disease Bruise or Bleed easily Leukemia</p>	<p>○ Yes ○ No ○ Yes ○ No ○ Yes ○ No ○ Yes ○ No</p>

