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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	○ Yes	○ No
Clicking or popping of the jaw	○ Yes	○ No
Grinding teeth	○ Yes	○ No
Jaw pain or tiredness	○ Yes	○ No
Orthodontic Treatment	○ Yes	○ No
Pain around ear	○ Yes	○ No

TEETH

Fingernail biting	○ Yes	○ No
Food collection between teeth	○ Yes	○ No
Loose teeth/broken fillings	○ Yes	○ No
Sensitivity to cold	○ Yes	○ No
Sensitivity to heat	○ Yes	○ No
Sensitivity to sweets	○ Yes	○ No
Sensitivity when biting	○ Yes	○ No

GUMS/MOUTH

Bad Breath	○ Yes	○ No
Bleeding Gums when brushing/flossing	○ Yes	○ No
Blisters on lips/mouth	○ Yes	○ No
Burning sensation on tongue	○ Yes	○ No
Dry mouth	○ Yes	○ No
Gums swollen or tender	○ Yes	○ No
Lip or cheek biting	○ Yes	○ No
Mouth breathing	○ Yes	○ No
Periodontal Treatment	○ Yes	○ No
Sores/growths in mouth	○ Yes	○ No

TOBACCO/ALCOHOL/DRUGS

Do you use **any** type of tobacco products?	○ Yes	○ No
Type_____		
Do you have a history of tobacco use?	○ Yes	○ No
When did you quit?_____		
Are you currently using any nicotine replacement product(s)?	○ Yes	○ No
Do you drink any alcoholic beverages?	○ Yes	○ No
Drinks per week_____		
Do you have a history of drug use?	○ Yes	○ No

MEDICAL HISTORY

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

Musculoskeletal			
Arthritis, Rheumatism	○ Yes ○ No	Have you ever taken any of the group of drugs collectively referred to as "biphosphonates"? These include Fosamax, Actonel, and/or Boniva.	○ Yes ○ No
Artificial Joints	○ Yes ○ No		
Need for antiobiotic pre-medication	○ Yes ○ No		
Back Problems	○ Yes ○ No		
Joint Pain	○ Yes ○ No		
Osteoporosis	○ Yes ○ No		

Women: Are you pregnant? ○ Yes ○ No Due Date:_____
Are you nursing? ○ Yes ○ No

MEDICATIONS	**ALLERGIES**
List any medications you are currently taking and the correlating diagnosis: _____ _____ _____ Pharmacy Name: _____ Phone: (_____) _____	○ Aspirin ○ Local Anesthetic ○ Barbiturates (Sleeping Pills) ○ Penicillin ○ Codeine ○ Sulfa ○ Iodine ○ Latex ○ Other: _____ _____

Financial Policy
I understand that I am financially responsible for all charges whether or not paid by insurance. Payment is due in full at the time of treatment Refusal to pay any and all outstanding balances could result in collection proceedings after 90 days delinquent.

Photograph Release
I hereby authorize Atlanta Dental Solutions to take photographs of my face, jaws, and teeth. I understand that the photographs will be used in a record of my care and may be used for research, publications, or educational purposes.

Consent from Treatment
I authorize diagnostic and preventative treatment including but not limited to examinations, radiographs, preventative hygiene cleanings, application of fluoride, & sealants. I further authorize the treatment of diseased or injured teeth & gums with dental restorations and/or removal of teeth, the replacement of missing teeth with dental prostheses, and scaling & root planning. I understand that there are risks involved in any treatment & hereby acknowledge that these risks & alternatives have been explained to me & that I will have an opportunity to ask questions regarding the risks, benefits, & alternatives of all treatment options, including no treatment. I understand that antibiotics, analgesics, & other medications can cause allergic reactions such as redness, swelling, pain, itching, and/or anaphylactic shock. I agree to the use of local anesthesia. I understand there are possible risks & complications associated with the administration of local anesthesia, sedation, & drugs. Unexpected severe complications with anesthesia can occur & include the possibility of infection, swelling, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting the Practice Manager.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

All of the preceding answers & information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Please Sign: I understand and agree to all of the above

Patient Signature _____ Date _____

Parent/ Guardian Signature _____ Date _____