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# McCONNELL FAMILY DENTISTRY

Version September 2011

The following information and health history are very important for us to provide you with the best possible dental care in a safe manner. Incorrect information may compromise your health. If you have any questions, please do not hesitate to ask. This information will become part of the patient record and will be considered confidential information. Thank you for choosing McConnell Family Dentistry for your dental health.

## Registration:

Date: _______________

Patient Name: ________________________________________ Patient is ○**Policy Holder** ○**Responsible Party**
Street Address: __________________________________City: ____________________State: ____ Zip: ______
Home phone: ______________________ Work Phone: __________________ Cell phone: __________________
Sex: ○Female ○Male Marital Status: ○Single ○Married ○Divorced ○Separated ○Widowed
Birth Date: _________________ Age: ____ Social Sec #: _________________ Drivers License #: ___________
Email Address: ____________________________________
Employment Status: ○Full Time ○Part Time ○Retired Student Status: ○Full Time ○Part Time
Employer: _________________________________ Employers phone: ____________________________

## Responsible Party (if not the patient)

○Responsible Party is also Policy Holder for the Patient

Name: __________________________________________
Street Address: __________________________________City: ____________________State: ____ Zip: ______
Home phone: ______________________ Work Phone: __________________ Cell phone: __________________
Birth Date: _________________ Age: ____ Social Sec #: _________________ Drivers License #: ___________

## Primary Dental Insurance:

Name of Insured: ___________________________ Relationship to Patient: ○Self ○Spouse ○Parent ○Other
Insured Soc. Sec. #: ________________ Insured Birth Date: _________________
Insured Employer: _______________________ Phone: ____________________
Employer Address: ________________________________City: ____________________State: ____ Zip: ______
Insurance Company: ________________________________
Insurance Address: ________________________________City: ____________________State: ____ Zip: ______

How did you hear about us? ______________________________________________________________
Is there anyone we can thank for referring you to our office? ____________________________________
____________________________________
In the unlikely event of an emergency, whom should we contact? ___________________________________
___________________________________

Patient Name: ___________________________

# McCONNELL FAMILY DENTISTRY

## Health History:

○Yes ○No Are you under a physician's care now? Name: ____________________________________

If yes, why? ____________________________________________________________________

Date of last doctor visit: ________________________

○Yes ○No Have you ever been hospitalized or had a major operation?

Explain ___________________________________________________________________________

○Yes ○No Have you ever had a serious head or neck injury? Explain: ____________________________

○Yes ○No Are you taking any medications, pills or drugs? Please List: ___________________________

_______________________________________________________________________________

○Yes ○No Do you take, or have you taken, Phen-Fen or Redux? ○Yes ○No Do you use Tobacco?

○Yes ○No Are you on a special diet? ○Yes ○No Do you use controlled substances?

Women are you ○Pregnant/Trying to get pregnant? ○Nursing ○Taking oral contraceptives?

Are you allergic to anything? Please list or check: ______________________________________________

○Aspirin ○Penicillin ○Codeine ○Acrylic ○Metal ○Latex ○Local Anesthetics

Please Check (Yes or No) if you have been or are being treated for any of the following:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Aids/HIV positive | ○Yes | ○No | Excessive Bleeding | ○Yes | ○No | Lung Disease | ○Yes | ○No |
| Alzheimer's Disease | ○Yes | ○No | Excessive Thirst | ○Yes | ○No | Mitral Valve Prolapse | ○Yes | ○No |
| Anaphylaxis | ○Yes | ○No | Fainting Spells/ Dizziness | ○Yes | ○No | Pain in Jaw Joints | ○Yes | ○No |
| Anemia | ○Yes | ○No | Frequent Cough/ bloody cough | ○Yes | ○No | Parathyroid Disease | ○Yes | ○No |
| Angina | ○Yes | ○No | Frequent Diarrhea | ○Yes | ○No | Psychiatric Care | ○Yes | ○No |
| Arthritis/Gout | ○Yes | ○No | Frequent Headaches | ○Yes | ○No | Radiation Treatments | ○Yes | ○No |
| Artificial Heart Valve | ○Yes | ○No | Genital Herpes | ○Yes | ○No | Recent Weight Loss | ○Yes | ○No |
| Artificial Joint | ○Yes | ○No | Glaucoma | ○Yes | ○No | Renal Dialysis | ○Yes | ○No |
| Asthma | ○Yes | ○No | Hay Fever | ○Yes | ○No | Rheumatic Fever | ○Yes | ○No |
| Blood Disease | ○Yes | ○No | Heart Attack/Failure | ○Yes | ○No | Rheumatism | ○Yes | ○No |
| Blood Transfusion | ○Yes | ○No | Heart Murmur | ○Yes | ○No | Scarlet Fever | ○Yes | ○No |
| Breathing Problem | ○Yes | ○No | Heart Pace Maker | ○Yes | ○No | Shingles | ○Yes | ○No |
| Bruise Easily | ○Yes | ○No | Heart Trouble/ Disease | ○Yes | ○No | Sickle Cell Disease | ○Yes | ○No |
| Cancer/ Tumors | ○Yes | ○No | Hemophilia | ○Yes | ○No | Sinus Trouble | ○Yes | ○No |
| Chemotherapy | ○Yes | ○No | Hepatitis A | ○Yes | ○No | Spina Bifida | ○Yes | ○No |
| Chest Pains (Angina) | ○Yes | ○No | Hepatitis B or C | ○Yes | ○No | Stomach/ Intestinal Disease | ○Yes | ○No |
| Cold Sores/ Blisters | ○Yes | ○No | Herpes | ○Yes | ○No | Stroke | ○Yes | ○No |
| Congenital Heart Disorder | ○Yes | ○No | High Blood Pressure | ○Yes | ○No | Swelling of Legs/Arms | ○Yes | ○No |
| Convulsions | ○Yes | ○No | Hives or Rash | ○Yes | ○No | Thyroid Disease | ○Yes | ○No |
| Cortisone Medicine | ○Yes | ○No | Hypoglycemia | ○Yes | ○No | Tonsillitis | ○Yes | ○No |
| Diabetes | ○Yes | ○No | Irregular Heartbeat | ○Yes | ○No | Tuberculosis (TB) | ○Yes | ○No |
| Drug Addiction | ○Yes | ○No | Kidney Problems | ○Yes | ○No | Tumors or Growths | ○Yes | ○No |
| Easily Winded | ○Yes | ○No | Leukemia | ○Yes | ○No | Ulcers | ○Yes | ○No |
| Emphysema | ○Yes | ○No | Liver Disease | ○Yes | ○No | Venereal Disease | ○Yes | ○No |
| Epilepsy or Seizures | ○Yes | ○No | Low Blood Pressure | ○Yes | ○No | Yellow Jaundice | ○Yes | ○No |

(over)

Have you ever had any serious illness NOT listed on the front? ○Yes ○No

If yes, please explain: ______________________________________________

______________________________________________

Have there been any changes in your health in the last year? ○Yes ○No

If yes, please explain: ______________________________________________

______________________________________________

**Dental History:**

What is your main dental concern? ______________________________________________

Are you worried about receiving dental treatment? ○Yes ○No

When was your last dental checkup/exam? ________________ Cleaning/Treatment?______________________

How often do you brush? ____________ Floss? _______________

Do you use toothpaste that does NOT contain Fluoride? ○Yes ○No

Have you ever had an unusual reaction to a dental procedure or anesthetics? ○Yes ○No

Explain:______________________________________________

Please check habits that may apply to you.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| ○ | Grind Teeth | ○ | Mouth Breather | ○ | Pipe | ○ | Suck Thumb/Finger | ○ | Candy |
| ○ | Bite Cheek | ○ | Anorexia/Bulimia | ○ | Bite Nails | ○ | Toothpick/Stimulator | ○ | Softdrinks |
| ○ | Tongue Thrust | ○ | Cigar/Cigarette | ○ | Smokeless Tobacco | ○ | Chewing Gum | ○ | |

Are your teeth sensitive to: Hot/cold ○Yes ○No Biting/chewing ○Yes ○No Sweets ○Yes ○No

Have you ever had: ○Orthodontic (Braces) Treatment ○Bite Guard/Plate ○Periodontic (Gum) Treatment ○Endodontic (Root Canal) Treatment ○Oral Surgery ○Injury to Mouth/Head

Do your gums bleed when you brush your teeth or when you eat? ○Yes ○No

Are any of your teeth loose? ○Yes ○No

Do you experience any pain or clicking in your jaw joint.? ○Yes ○No

Are there any sores or growths in your mouth? ○Yes ○No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. I agree to inform the dental office of any changes in medical status as soon as possible. I give my permission to the dentist to obtain from my physician any additional information regarding the medical history needed to provide optimal care.

______________________________________________

Signature of PATIENT, PARENT, or GUARDIAN DATE