HAMPSHIRE FAMILY DENTAL REGISTRATION AND HEALTH HISTORY

PATIENT INFORMATION

Name: ________________________________ ____________________ ____ **How do you prefer to be addressed?**__________________________
Last **First** **MI**
Mailing Address____ **City** ____________________ **State**_____________ **Zip**_____________

Sex: M F Age:_________ **Birth date:**___________________ **Child Single Married Divorced Widow SS#**_____________________________

Home Tel. #_____________________________ **Work tel. #**_________________________________ **Cell tel. #**___________________________________

If Student, name of College__________________________________ **City**____________________ **State**______________ **PT FT**

E-mail Address:____

How did you hear about us?____**Newspaper**____**Yellow Pages**_____**Internet**____**Drive by**____**Patient name:**_________________________________

If the person responsible for this patients account is different from the patient or if the patient is a minor, the responsible party must fill out the section below. Otherwise, Please skip to section titled "Insurance Information".

Name of responsible party/legalguardian____**Relationship to patient**____________________

Mailing Address__________________________________**City**__________________________________**State**________________**Zip Code**__________________

Home tel. #______________________________**Work tel #**______________________________________**Cell #**____

DENTAL INSURANCE INFORMATION

Subscribers Name_________________________________**Relationship to Patient**______________________________**SS#**_______________________________

DOB of Subscriber___________________________**Name of Employer**___________________________________**Effective date**___________________________

Name of Insurance Co.____________________________________**Group #**___________________________**Tel #**____

SECONDARY DENTAL INSURANCE INFORMATION

Subscribers Name_________________________________**Relationship to Patient**______________________________**SS#**_______________________________

DOB of Subscriber___________________________**Name of Employer**__________________________________**Effective date**___________________________

Name of Insurance Co.____________________________________**Group #**___________________________**Tel #**____

MEDICAL INFORMATION

ALLERGIES

Aspirin
Antibiotics
Barbiturates
Codeine
Environmental
Iodine
Latex
Local Anesthetic
Metals
Penicillin
Sulfa
Other:________________________

MEDICATIONS :

Please list all medications & reasons for taking:
____
____
____
____

Women

Are you currently pregnant? **Yes No If yes, what is your due date?**_______
Are you breast feeding? **Yes No**
Are you taking oral contraceptives? **Yes No**

Answers to the following questions are for our records only and will be considered confidential.

1. Have you or any member of your family been seen by us before? **Yes** **No**
   If yes, which family member (s)?____
2. Date of last physical exam______________________ Physician Name ______________________
3. Date of last dental exam ______________________ Date of last dental x-rays______________________
4. Previous dentists name______________________ City/State______________________
5. Are you having pain or discomfort at this time? **Yes** **No**
6. Do you feel nervous about having dental treatment? **Yes** **No**
7. Have you ever had a bad experience in a dental office? **Yes** **No**
8. Is there anything you dislike about your smile? **Yes** **No**
9. Is there anything you would like to speak to the Dr. about in private? **Yes** **No**
10. Have you been a patient in the hospital in the past two years? **Yes** **No**
11. Have you been under the care of a medical Dr. during the past two years? **Yes** **No**
12. Have you taken any medication or drugs in the last two years/ **Yes** **No**
    If so, what? ____
13. Are you taking any vitamins, herbal supplements or "cures"? **Yes** **No**
14. Have you ever had difficult extractions in the past? **Yes** **No**
15. Have you ever had prolonged bleeding following extractions? **Yes** **No**
16. Do you habitually clench or grind your teeth during the day or night? **Yes** **No**
17. Have you ever been told you have gum problems? **Yes** **No**
18. Have you ever needed to see a periodontist? **Yes** **No**
19. Do you now have bleeding gums or any other gum condition? **Yes** **No**
20. Is there anything related to your medical or dental history that you have not indicated above?
    If **yes**, please explain____

Circle YES or NO to indicate if you have had any of the following:

Chest Pain	**Yes**	**No**	Shortness of breath	**Yes**	**No**	Hives or skin rash	**Yes**	**No**
Heart Failure	**Yes**	**No**	Ulcers	**Yes**	**No**	Alcoholism	**Yes**	**No**
Heart Disease or attack	**Yes**	**No**	Cholesterol issues	**Yes**	**No**	Herpes	**Yes**	**No**
Angina Pectoris	**Yes**	**No**	Emphysema	**Yes**	**No**	Glaucoma	**Yes**	**No**
Heart Problems	**Yes**	**No**	Fainting or dizzy spells	**Yes**	**No**	*Steroid Treatment	**Yes**	**No**
High Blood Pressure	**Yes**	**No**	Epilepsy or seizures	**Yes**	**No**	Arthritis	**Yes**	**No**
*Heart Murmur	**Yes**	**No**	Persistent Cough	**Yes**	**No**	*Any type of implant	**Yes**	**No**
*Rheumatic Fever	**Yes**	**No**	Tuberculosis (TB)	**Yes**	**No**	Dentures or Partials	**Yes**	**No**
Psychiatric Treatment	**Yes**	**No**	*Congenital Heart Prob.	**Yes**	**No**	Birth Defects	**Yes**	**No**
Sickle Cell Disease	**Yes**	**No**	Asthma	**Yes**	**No**	HIV Positive, ARC, AIDS	**Yes**	**No**
Sinus Trouble	**Yes**	**No**	Hepatitis A (infectious)	**Yes**	**No**	Use of tobacco products	**Yes**	**No**
*Artificial Joints/Valves	**Yes**	**No**	Hepatitis B (serum)	**Yes**	**No**	**How long?______ How much?_______**		
Diabetes	**Yes**	**No**	Hepatitis C	**Yes**	**No**	Bruise easily	**Yes**	**No**
Thyroid Disease	**Yes**	**No**	Heart Pacemaker	**Yes**	**No**	Jaundice	**Yes**	**No**
Anemia	**Yes**	**No**	Stroke	**Yes**	**No**	Heart Surgery	**Yes**	**No**
Blood Transfusion	**Yes**	**No**	Drug addiction	**Yes**	**No**	Kidney trouble	**Yes**	**No**
*Any type of transplant	**Yes**	**No**	Cold Sores	**Yes**	**No**	Hemophilia	**Yes**	**No**
*Mitral Valve Prolapse	**Yes**	**No**	Radiation therapy	**Yes**	**No**	Cancer (type:)	**Yes**	**No**
Lyme Disease	**Yes**	**No**	Covid-19	**Yes**	**No**			

***Have you ever taken medication for osteoporosis or osteopenia? ____Yes_____No (what & how long)_____________________**

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that by providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. **I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.**

X____ _______________________________

Signature of patient/parent/guardian **Date**