SINADA DENTAL

Registration and Health History

Reason for Visit:_____ Date:_____

Patient's Name:_____DOB:_____ SS#:_____

If Patient is minor, Parent Guardian name:_____

Address:_____City:_____ State:_____ ZIP:_____

Cell#_____ Home#_____Work#_____

Email:_____ Preferred Method of Contact:_____

DL#_____ Sex: M / F Marital Status: _____ Employer:_____

Emergency Contact:_____
(Name) (phone#) (relation to patient)

How did you hear about this office?_____

Dental Insurance Information

Insured's Name:_____ DOB:_____Relation to Patient:_____

Insured's SS#_____ Insured's Employer:_____

Insured's Address (if different): _____

Insurance Company:_____ Group# _____ Effective Date_____

Claims Address:_____ Phone #_____

Minors

Age 17 and under must be accompanied by a parent or guardian for all appointments and are required to remain in the office until treatment is completed. The adult accompanying the minor is responsible for the balance due. Payment is expected at time of service.

Please assist us, as a partner in your dental health, by following our policies. If at any time you have questions or concerns regarding our policies or your account, please do not hesitate to contact our Practice Manager for assistance.

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Medical and Dental History

It is important that we know your medical and dental history. These facts have a direct bearing on your dental and overall health. The information is strictly confidential and will not be released to anyone without approval. Thank you for completely filling out this questionnaire.

How long since last dental visit:_____ Reason of visit:_____

How long since X-rays were taken:_____ Date of Last Complete Dental Exam:_____

Did you have any problems with last dental treatment:_____

Previous Dentist's Name:_____ Phone Number:_____

Major Dental Concern:_____

Y N Do your gums bleed while brushing or flossing?

Y N Are your teeth sensitive to hot/cold foods?

Y N Are your teeth sensitive to sweet/sour foods?

Y N Do you feel pain to any of your teeth?

Y N Do you have any sores or lumps in or near your mouth?

Y N Have you had head, neck, or jaw injuries?

Y N Have you ever experienced any of the following problems in your jaw?

- ❑ Clicking
- ❑ Pain (joint, ear, side of face)
- ❑ Difficulty opening or closing
- ❑ Difficulty chewing

Y N Do you have frequent headaches?

Y N Do you clench or grind your teeth?

Y N Do you bite your lips or cheeks frequently?

Y N Have you had difficult extractions in the past?

Y N Have you ever had issues with prolonged bleeding following any procedure?

Y N Have you had orthodontic treatment?

Y N Do you wear dentures or partials?
If yes, date started_____

Y N Have you received oral hygiene instructions regarding the care of your teeth and gums?

Y N Do you like your smile?

Physician:_____ Phone:_____

Current Medications:_____

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Medical and Dental History Continued...

Circle any medications to which you are ***allergic*** or have had a reaction to in the past:

Aspirin Metals Barbiturates Iodine Latex Local Anesthetic Nitrous Oxide Penicillin Sulfa

Other Allergies:_____

Y N Are you currently under Medical treatment?

Y N Do you use tobacco? ____Smoke ____Chew How much/often?_____

Y N Have you been hospitalized for any surgical operation or serious illness within last 5 years? If Yes, please explain:_____

Y N Are you pregnant or think you may be pregnant? Y N Are you nursing?

Y N Are you taking oral contraceptives?

Check any that you have or have had in the past:

High Blood Pressure	Anemia
Heart Attack	Emphysema
Rheumatic Fever	Cancer
Swollen Ankles	Arthritis
Fainting/Seizures	Joint Replacement or Implant
Asthma	Chest Pain
Low Blood Pressure	Easily Winded
Epilepsy/Convulsions	Stroke
Leukemia	Hay Fever/Allergies
Diabetes	Radiation Therapy
Heart Disease	Tuberculosis
Cardiac Pacemaker/defibrillator	Glaucoma
Heart Murmur	Recent Weight Change
Angina	Liver Disease
Kidney Disease	Heart Problems
AIDS/HIV	Hepatitis/Jaundice
Thyroid Problem	Sexually Transmitted Disease
	Stomach Troubles/Ulcers
	Respiratory Problems
	Mitral Valve Prolapse

Is there any other medical or dental information that you feel we should know about?

_____

_____ _____

Patient or Parent/Guardian Signature Date