



Legacy Dental

Patient Number _____

A B C

HEALTH HISTORY & REGISTRATION

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ Middle Initial _____ SEX: M F BIRTHDATE _____ AGE _____
 Soc. Sec. # _____ If Patient is a Minor, give Parent's or Guardian's Name _____ TODAY'S DATE _____
 Who May We Thank for Referring You to our Office? _____ Reason for this Visit _____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle Initial _____ MARITAL STATUS _____
 RESIDENCE Street _____ Apt. # _____ City _____ State _____ Zip _____
 MAILING ADDRESS Street _____ Apt. # _____ City _____ State _____ Zip _____
 HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ CELL PHONE _____
 WORK PHONE _____ E-MAIL _____
 PREVIOUS ADDRESS (if less than 3 yrs.) Street _____ City _____ State _____ Zip _____ How Long _____
 SOCIAL SECURITY # _____ BIRTHDATE _____ DRIVER'S LICENSE # _____ RELATION TO PATIENT _____
 EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

RESPONSIBLE PARTY'S SPOUSE

NAME _____
LAST FIRST MIDDLE
 EMPLOYER _____ OCCUPATION _____ ()
NO. YEARS EMPLOYED
 SOC. SEC. # _____ BIRTHDATE _____
 HOME PH. _____ CELL PH. _____
 WORK PH. _____ E-MAIL _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME _____ RELATIONSHIP _____
 ADDRESS _____ CITY, STATE _____
 HOME PH. _____ CELL PH. _____
 WORK PH. _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____
 Insurance Co. _____ E-MAIL _____
 Insurance Co. Address _____
 Insured's Employer _____
 Insured's Soc. Sec. # _____ Group # _____ Local # _____

If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name _____
 Insurance Co. _____ E-MAIL _____
 Insurance Co. Address _____
 Insured's Employer _____
 Insured's Soc. Sec. # _____ Group # _____ Local # _____

Dental Information *Please mark (X) your responses to the following questions.*

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink bottled or filtered water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam?			
If yes, how often? Circle one: DAILY / WEEKLY / OCCAISONALLY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What was done at that time?			
Are you currently experiencing dental pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of last dental x-rays:			
Name of previous dentist:							
What is the reason for your dental visit today?							
How do you feel about your smile?							

Patient's Signature (Parent of Child) _____ Date _____

Dental and Health Questionnaire

The health of your body and certain health conditions or medications can have significant interactions with the treatment you receive. Please answer the following questions as accurately as possible. Thank you.

Name: _____ Date: _____ Date of Birth: ____/____/____

HEALTH HISTORY

Are you under the care of a medical doctor? ___Yes ___No (If yes please explain below)

Please provide your doctor's name and telephone number: _____

Date of your last physical exam (approximately): _____

Have you been hospitalized in the last two years? ___Yes ___No (If yes please explain below)

Are you taking medications or herbal supplements ___Yes ___No (If yes please list **ALL**)

Are you allergic to or have you reacted adversely to any of the following medications?

- Aspirin Local Anesthetic Erythromycin Latex (balloons, gloves, etc.)
 Nitrous Oxide Codeine Penicillin

Are you aware of being allergic to any other medications or substances? ___Yes ___No

If yes, please list: _____

Is there any other Medical or Dental information that you feel I should know about? ___Yes ___No

Do you take aspirin on a daily basis? ___Yes ___No If yes, how many mg _____

Do you Pre-medicate with antibiotics prior to your dental appointments for artificial joints or a heart condition? ___Yes ___No (If yes, please list the reason why & which antibiotic you take)

Have you ever taken bone density/osteoporosis (bisphosphonates) medications? ___Yes ___No

If yes, what medication, when and for how long? _____

Do you smoke or chew tobacco products? ___Yes ___No If yes, how much _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Please check **any** that apply:

- | | | |
|--|--|---|
| <input type="checkbox"/> Acid Reflux/GERD | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Nervous Problems |
| <input type="checkbox"/> Aids | <input type="checkbox"/> Eye disease/glaucoma | <input type="checkbox"/> Organ transplant |
| <input type="checkbox"/> Alzheimer | <input type="checkbox"/> Fainting/dizziness | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Heart attack/failure | <input type="checkbox"/> Radiation treatments |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Rheumatism/arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Heart valve replacement | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Hepatitis Type _____ | <input type="checkbox"/> Sleep disorder |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Stomach disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes TYPE _____ | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Tumors/growths |
| <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Lung disease/COPD | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mitral valve problems | <input type="checkbox"/> Venereal disease (STD) |

Do you have any condition/disease that is not listed above: ___Yes ___No

If yes, please explain: _____