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 _____

RESPOSIBLE 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
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCAISIONALLY	☐	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam?
What was done at that time?

Name of previous dentist:

Date of last dental x-rays:

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 Questionaire

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:

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

Do you have any condition/disease that is not listed above: ___Yes ___No
If yes, please explain: _____