REGISTRATION AND HEALTH HISTORY

Title: Mr. Mrs. Ms. Dr. Today's Date _____

Patient's Name _____ Birthdate _____
First M.I. Last

Single _____ Married _____ Male _____ Female _____

Nickname or how do you wish to be addressed _____ Social Security # _____

Home Address/Mailing Address _____

Email _____

City _____ State _____ Zip _____ Phone _____ Cell _____

Patient employed by _____ Business Phone _____

Business Address _____

Present Position _____ How long held _____

Name of Spouse/Parent/Guardian _____ Spouse employed by _____

Referred by _____

Emergency Contact _____ Phone _____

I UNDERSTAND THAT I AM FULLY FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER COVERED OR NOT COVERED OR DENIED BY MY INSURANCE COMPANY.

Signature: _____ Relationship: _____

We request payment at the time of service, unless prior arrangements have been made.
We accept check, cash or credit card.
18% Interest per month is applied to accounts after 60 days.

DENTAL INSURANCE INFORMATION

Name and Address of Insurance Company _____

Primary _____ Secondary _____

_____

Policy/Group # _____ Policy/Group # _____

Employee Name _____ Employee Name _____

Birthdate _____ Birthdate _____

Social Security # _____ Social Security # _____

INSURANCE RELEASE: I authorize release of any information required by my insurance company.

Signature _____

PAYMENT RELEASE: I authorize my insurance benefits to be paid directly to Byron Dental Group.

Signature _____

MEDICAL HISTORY

SPECIAL ALERT

Name of medical doctor ______________________________

If Mayo Clinic, patient number ______________________________

Do you have any general health problems? ______________________________

____

Any current or upcoming medical treatment? ______________________________

Have you had any recent surgeries? ______________________________

If so, for what and when? ______________________________

Do you need antibiotics for dental treatment? yes __________ no __________

Do you routinely take any medication (prescription or nonprescription)? ____ If so, what? ______________________________

____

Have you ever had any of the following? (Please check which ones)

- ☐ Acid Reflux
- ☐ AIDs
- ☐ Alcoholism
- ☐ Allergies or Hives
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Angioplasty/Shunts
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints/Plates/ Pins/Prosthesis
- ☐ Asthma
- ☐ Bisphosphonate Therapy eg.(FOSAMAX)Aredia Actone
- ☐ Blood Transfusion
- ☐ Bulimia/Anorexia
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cold Sores
- ☐ Congenital Heart Lesions
- ☐ Congestive Heart Failure
- ☐ Cough Up Blood
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy Spells
- ☐ Fibromyelgia
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur/ Mitral Valve Prolapse
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis A – B – C
- ☐ Hepatitis B Vaccine
- ☐ High/Low Blood Pressure
- ☐ HIV Positive Test
- ☐ Kidney Trouble
- ☐ Liver Disease
- ☐ Multiple Sclerosis
- ☐ Nervousness
- ☐ Osteoporosis
- ☐ Psychiatric Treatment
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tobacco Usage
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Are You Pregnant/Nursing? Due Date ______________
- ☐ Other ______________ ______________

Have you become sick from, shown any allergy to, or been told not to take:

yes	no		yes	no		yes	no	
☐	☐	Local Anesthetic (novocaine)	☐	☐	Aspirin	☐	☐	Iodine
☐	☐	Penicillin	☐	☐	Any Metal Allergies	☐	☐	Latex
☐	☐	Other Antibiotics __________	☐	☐	Barbiturates (sleeping pills)	☐	☐	Other ______________
☐	☐	Sulfa	☐	☐	Codeine			

____

Signature Date

I have reviewed the above medical history.

Changes yes	no		Changes yes	no		Changes yes	no	
☐	☐	______________ Initials & Date	☐	☐	______________ Initials & Date	☐	☐	______________ Initials & Date
☐	☐	______________ Initials & Date	☐	☐	______________ Initials & Date	☐	☐	______________ Initials & Date
☐	☐	______________ Initials & Date	☐	☐	______________ Initials & Date	☐	☐	______________ Initials & Date
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☐	☐	______________ Initials & Date	☐	☐	______________ Initials & Date	☐	☐	______________ Initials & Date

DENTAL HISTORY UPDATE

1. Who was your previous dentist? _____
2. When was your last dental visit? _____ Yes No
3. Do you have any concerns about your teeth? ____ ____
   a. Are your teeth sensitive to heat, cold, sweets, biting pressure? ____ ____
   b. Are you presently having pain? ____ ____
   c. Are you aware of decayed teeth? ____ ____
   d. Do you have rough or broken fillings? ____ ____
   e. Does food catch between your teeth? ____ ____
4. How do you feel about your smile? OK ____ Not OK ____
5. If there was anything you could change about your teeth or smile, what would that be?

   Nothing _____

   I would like to change the following:

   ____ Brightness of my teeth
   ____ Have my teeth better aligned
   ____ The shape of my teeth
   ____ The color of my teeth

	Yes	No
6. Do you participate in any contact sports?	____	____
Do you have a mouthguard?	____	____
7. Do you ever experience grinding or clenching teeth?	____	____
a. Do any teeth feel loose?	____	____
b. Have you had any pain in jaw or area of ears?	____	____
c. Do you have frequent headaches or neck pain?	____	____
d. Have you had any previous injury to the face or jaw?	____	____
e. Do you wear a niteguard or splint?	____	____
f. Have you had orthodontics?	____	____
8. Are you concerned about whether or not you are maintaining adequate oral hygiene?	____	____
9. If you feel you are not, are you concerned about the consequences?	____	____

If yes, please indicate: _____

a. Do you have a family history of gum/periodontal disease?	____	____
b. Do your gums bleed when you brush?	____	____
c. Have you had gum surgery or treatments?	____	____
d. Are you aware of any unpleasant taste?	____	____
e. Are you aware of ever having bad breath?	____	____
f. Are you a tobacco user? Type? _____	____	____

g. How often do you brush your teeth? _____
h. How often do you floss your teeth? _____
i. How would you rate your fear of dental treatment?

____ Excessive ____ Moderate ____ Low

I give the attending dentist consent to use local anesthetic as needed:

Signature: _____

I give the attending dentist consent to the use of nitrous oxide per my request:

Signature: _____

I have reviewed the information on this questionaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor and staff to help determine appropriate dental treatment. If there are any changes in my medical status, I will inform the dentist. Since at each visit a treatment plan will be presented and the work to be done is explained to me before. I give the attending dentist my consent to perform any needed dental treatment.

Signature: _____

Each time you arrive for your appointment, we will have you sign and date your Medical and Dental History as required by law.

This information is NOT shared with anyone outside this office. This material is strictly confidential and collected solely for the use of this office.