HEALTH HISTORY AND PATIENT REGISTRATION FORM
IMPLANT DENTISTRY OF GREATER LANSING

Date _____

Name _____ Please check one: ◯Mr. ◯Mrs. ◯Ms. ◯Miss ◯Dr.

Address _____City _____ State _____ Zip _____

Previous address if less than 3 years _____City _____ State _____ Zip _____

Phone: Home (_____) _____ - _____ Work (_____) _____ - _____ Cell (_____) _____ - _____

E-mail Address: _____ Birthdate _____ Age _____ Sex: ◯F ◯M

Please check one: single married widowed separated divorced

Place of employment _____occupation _____ How long employed _____

Address of employment _____

Social Security # _____ Insurance Contract # _____

IF MARRIED

Spouse's Name _____ Birthdate _____ Social Security # _____

Referred by: Doctor: _____ Patient: _____

◯ Yellow pages ◯ Advertisement ◯ Newspaper ◯ Radio

Nearest Neighbor or Relative's Name, Address and Phone No. _____

INSURANCE INFORMATION

Primary Insurance Coverage _____ Second Insurance Coverage _____

Insured's Name _____ Insured's Name _____

Insurance Co. _____Insurance Co. _____

Insurance Co. Address _____ Insurance Co. Address _____

Insured's Employer _____Insured's Employer _____

Group or Policy # _____ Group or Policy # _____

Type of Insurance Dental Type of Insurance Dental

Name of Previous Dentist _____Last visit _____

MEDICAL HISTORY

For the following questions, check yes or no, whichever applies. Your answers are for our records only and will be considered confidential. These facts have a direct bearing on your dental health.

1. Are you in good health? . . . . . YES◯ NO◯
2. Has there been any change in your general health within the year?. . . . . YES◯ NO◯
3. My last physical examination was on _____
4. Are you now under a physicians care? . . . . . YES◯ NO◯

   If so, for what condition are you being treated _____
5. The name and address of your physician is _____
6. Have you had any serious illness or operation? . . . . . YES◯ NO◯

   If so, what was the illness or operation _____
7. Have you been hospitalized or had a serious illness with in the last 5 years?. . . . . YES◯ NO◯
8. Have you had any history of Tumors, Malignancies or treatment of cancer, of any nature? . . . . . YES◯ NO◯
9. Do you have or have you ever had any of the following:
   - A. Rheumatic fever or Rheumatic heart disease? . . . . . YES◯ NO◯
   - B. Congenital heart disease? . . . . . YES◯ NO◯
   - C. Heart Murmur? . . . . . YES◯ NO◯
   - D. Allergy? . . . . . YES◯ NO◯
   - E. Asthma or hay fever? . . . . . YES◯ NO◯
   - F. Sinus Trouble? . . . . . YES◯ NO◯
   - G. Hives or skin rash? . . . . . YES◯ NO◯

H. Fainting spells or seizures? . . . . . YES ◯ NO ◯
I. Epilepsy? . . . . . YES ◯ NO ◯
J. Hepatitis, Jaundice or Liver disease?. . . . . YES ◯ NO ◯
K. Arthritis? . . . . . YES ◯ NO ◯
L. Have you ever been tested for HIV virus . . . . . YES ◯ NO ◯
Results: _____negative _____positive
M. Inflammatory rheumatism? . . . . . YES ◯ NO ◯
N. Stomach Ulcers. . . . . YES ◯ NO ◯
O. Cardiovascular disease, Heart disease:
(heart trouble, heart attack, stroke, coronary insufficiency, coronary damaged heart valves, heart murmur, artificial heart valve, Mitral valve prolapse, heart surgery, etc.). . . . . YES ◯ NO ◯
P. Kidney Trouble? . . . . . YES ◯ NO ◯
Q. Do you have a persistent cough or cold? . . . . . YES ◯ NO ◯
R. Diabetes? . . . . . YES ◯ NO ◯
Do you have to urinate more than six times a day?. . . . . YES ◯ NO ◯
Are you thirsty much of the time?. . . . . YES ◯ NO ◯
Does your mouth feel frequently dry?. . . . . YES ◯ NO ◯
S. Low Blood Pressure? . . . . . YES ◯ NO ◯
T. Tuberculosis . . . . . YES ◯ NO ◯
U. Venereal Disease? (Syphilis, Gonorrhea, etc) . . . . . YES ◯ NO ◯
V. Sickle Cell Disease? . . . . . YES ◯ NO ◯
W. Other _____
X. Cancer of chemotherapy, or radiation treatment, Leukemia?. . . . . YES ◯ NO ◯
Y. Glaucoma (open, closed angle) . . . . . YES ◯ NO ◯
Z. Night sweats . . . . . YES ◯ NO ◯

10. Have you had an artificial hip, knee or other replacement surgery?. . . . . YES ◯ NO ◯
11. Have you had abnormal bleeding associated with any previous surgery, extraction or trauma? . . . . YES ◯ NO ◯
12. Do you have any blood disorder(s)? Anemia? . . . . . YES ◯ NO ◯
    Any family history of bleeding disorders? . . . . . YES ◯ NO ◯
13. Are you taking any medicine? . . . . . YES ◯ NO ◯
    If so, what _____
14. Do you smoke? . . . . . YES ◯ NO ◯
15. Do you chew tobacco? . . . . . YES ◯ NO ◯
16. Are you taking any of the following? If yes, please list name.
    Antibiotic or sulfa drugs? . . . . . YES ◯ NO ◯
    Anticoagulant? . . . . . YES ◯ NO ◯
    Medicine for high blood pressure? . . . . . YES ◯ NO ◯
    Tranquilizers? . . . . . YES ◯ NO ◯
    Cortisone, steriods?. . . . . YES ◯ NO ◯
    Aspirin? . . . . . YES ◯ NO ◯
    Antihistamines? . . . . . YES ◯ NO ◯
    Insulin, tolbutamide, orinase or similar drug . . . . . YES ◯ NO ◯
    Digitalis or drugs for heart disease? . . . . . YES ◯ NO ◯
    Nitroglycerin?. . . . . YES ◯ NO ◯
    Other _____
17. Are you allergic to or have your reacted adversely to:
    Local Anesthetics?. . . . . YES ◯ NO ◯
    Penicillin or other antibiotics . . . . . YES ◯ NO ◯
    Sulfa Drugs? . . . . . YES ◯ NO ◯
    Barbiturates, sedatives, or sleeping pills? . . . . . YES ◯ NO ◯
    Aspirin? . . . . . YES ◯ NO ◯
    Iodine? . . . . . YES ◯ NO ◯
    Codeine or other narcotics? . . . . . YES ◯ NO ◯
    Other _____
18. Do you have any disease, condition, or problem not listed above that you think we should know about?
19. Are you employed in a position which exposes you regularly to x-rays or any other ionizing radiation? YES ◯ NO ◯
20. Are you wearing contact lenses? . . . . . YES ◯ NO ◯

DENTAL HISTORY

1. What is your chief dental complaint?

_____

_____

2. Please give a brief dental history of this problem

_____

_____

3. Are you satisfied with the appearance of your teeth? . . . . . YES ◯ NO ◯
4. Are you able to eat and chew food satisfactorily?. . . . . YES ◯ NO ◯
5. Are you experiencing any discomfort or pain at this time? . . . . . YES ◯ NO ◯
6. Do you have headaches, earaches, or neck pain? . . . . . YES ◯ NO ◯
7. Do you frequently experience sinus problems? . . . . . YES ◯ NO ◯
8. Have you had any serious trouble associated with any previous dental treatment? . . . . . YES ◯ NO ◯
   If yes, please explain _____

WOMEN

1. Are you pregnant? . . . . . YES ◯ NO ◯
2. Are you taking oral contraceptives or hormonal therapy?. . . . . YES ◯ NO ◯
3. Are you Nursing?. . . . . YES ◯ NO ◯

Please rank the following in order of which they would keep you from having dental treatment.

4. # _____ FEAR of pain, surgery, injections.
5. # _____ FEE for treatment.
6. # _____ TIME off work.
7. # _____ RESULTS expected.
8. # _____ NOCONCERNS.

RESPONSIBILITY AND CONSENT STATEMENT

I hereby authorize and request the performance of dental services for myself or for:

_____

I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purposed or dental treatment.

(Such as study models, photographs, and x-rays.)

I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage. Treatment plans involving extended credit circumstances may have a credit check done on my credit rating.

_____ _____

(signature of patient) (date)

Print Only