



WELCOME TO OUR OFFICE

(FOR OFFICE USE ONLY)

Date \_\_\_\_\_

I.D. # : \_\_\_\_\_

MEDICAL ALERT box

REGISTRATION INFORMATION

The patient is an: Adult [ ] Child [ ] Adult under guardianship [ ] Guardian \_\_\_\_\_

Dr. [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Miss [ ]

Name: last name first name Initial prefers to be called

Address: street Apt. # city postal code

Bus. Phone: ( ) - May we call you at work? Yes [ ] No [ ]

Home Phone: ( ) - Age: Sex: Marital Status: \_\_\_\_\_

Cell Phone: ( ) - , email address: @ \_\_\_\_\_

Birth Date: Mo. Day Year \_\_\_\_\_

Employer: Occupation: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Person responsible for account: S.I.N. of this person: \_\_\_\_\_

MEDICAL PRIORITY

Family Physician: name address phone

Are you under the care of a Medical Specialist? Yes [ ] No [ ] Type of Specialist: \_\_\_\_\_

name address phone

In case of emergency, please contact: name phone

INSURANCE INFORMATION

Do you have insurance? Yes [ ] No [ ] Insurance Co. Name: \_\_\_\_\_

Insurance Holder's Name: Name of Spouse: \_\_\_\_\_

Birth Date of Insurance Holder: Mo. Day Yr. \_\_\_\_\_

Policy No.: Certificate No.: Group No.: Division No.: \_\_\_\_\_

Maximum Coverage (Yearly): \$ Percentage Covered: % Deductible: \$ \_\_\_\_\_

Do you have two insurance policies? Yes [ ] No [ ] If yes, please fill out the section below:

Second Insurance Co. Name: Insurance Holder's Name: \_\_\_\_\_

Birth Date of Insurance Holder: Mo. Day Yr. \_\_\_\_\_

Policy No.: Certificate No. Group No.: Division No.: \_\_\_\_\_

## HEALTH HISTORY

Yes No

1. Are you currently receiving care from a physician? \_\_\_\_\_
2. Were you ever seriously ill or hospitalized? \_\_\_\_\_
3. Are you currently on any drugs or medications? \_\_\_\_\_
4. Please indicate if you have a serious reaction to any of the following medication:  
 Antibiotics  Sleeping pills  Antibiotics  Codein  Darvon
5. Please let us know if you have been warned against taking any medication \_\_\_\_\_
6. Have you ever used medicinal or non-medicinal drugs on a regular basis? \_\_\_\_\_
7. Do you have any allergies we should know about? \_\_\_\_\_
8. Are you a smoker? \_\_\_\_\_
9. Have you ever fainted, felt out of breath, or had chest pains? \_\_\_\_\_

Please indicate if you have or had any of the following:

- |   |   |  |   |   |
|---|---|--|---|---|
| <input type="checkbox"/> A.I.D.S.               | <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Heart murmur            | <input type="checkbox"/> Liver disease            | <input type="checkbox"/> Sinus trouble      |
| <input type="checkbox"/> Alcohol Dependence     | <input type="checkbox"/> Circulation problems     | <input type="checkbox"/> Heart pacemaker/surgery | <input type="checkbox"/> Leukemia                 | <input type="checkbox"/> Stomach/intestinal |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Congenital heart lesions | <input type="checkbox"/> Heart rhythm disorder   | <input type="checkbox"/> Lung disease             | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Angina pectoris        | <input type="checkbox"/> Cortisone/steroid        | <input type="checkbox"/> Hepatitis A/B/C         | <input type="checkbox"/> Malignant hyperthermia   | <input type="checkbox"/> Thyroid disease    |
| <input type="checkbox"/> Anorexia nervosa       | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Herpes                  | <input type="checkbox"/> Mental disorder          | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Arthritis/rheumatism   | <input type="checkbox"/> Drug dependence          | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Mitral valve prolapse    | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Emphysema                | <input type="checkbox"/> H.I.V. positive         | <input type="checkbox"/> Organ transplant/implant | <input type="checkbox"/> Venereal disease   |
| <input type="checkbox"/> Artificial joints      | <input type="checkbox"/> Epilepsy or seizures     | <input type="checkbox"/> Hodgkins disease        | <input type="checkbox"/> Osteoporosis             | <input type="checkbox"/> Other              |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Glandular disorder       | <input type="checkbox"/> Hyper (Hypo) glycemia   | <input type="checkbox"/> Psychiatric treatment    | <input type="checkbox"/> None               |
| <input type="checkbox"/> Blood disorders        | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Hypertension            | <input type="checkbox"/> Radiation/Chemotherapy   |   |
| <input type="checkbox"/> Bronchitis             | <input type="checkbox"/> Head/neck injuries       | <input type="checkbox"/> Jaundice                | <input type="checkbox"/> Rheumatic/Scarlet fever  |   |
| <input type="checkbox"/> Bulimia                | <input type="checkbox"/> Heart disease            | <input type="checkbox"/> Kidney disease          | <input type="checkbox"/> Sickle cell disease      |   |

10. **Women:** Are you pregnant?  Y  N      Menopause?  Y  N      Birth control?  Y  N

**Children:** Please indicate if you had any of the following:

- |                                      |                                  |                                |                                       |                                      |
|--------------------------------------|----------------------------------|--------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Strep Throat | <input type="checkbox"/> Tonsillitis |
|--------------------------------------|----------------------------------|--------------------------------|---------------------------------------|--------------------------------------|

## DENTAL HISTORY

Yes No

1. Please indicate the reason for today's visit:  Examination       Emergency       Other
2. Approximately how often do you see a dentist? \_\_\_\_\_
3. How often do you brush? \_\_\_\_\_
4. Are your teeth sensitive to:  Cold       Sweets       Heat       Other
5. Have your gums bled when brushing or flossing? \_\_\_\_\_
6. Do your gums feel swollen or tender? \_\_\_\_\_
7. Do you feel that you have bad breath? \_\_\_\_\_
8. Do you experience any popping/clicking in your jaw joints? \_\_\_\_\_
9. Do you grind or clench your teeth? \_\_\_\_\_
10. Does food catch between your teeth? \_\_\_\_\_
11. Have you ever had local anesthetic (freezing)? \_\_\_\_\_
12. Have you ever had complications due to anesthetics? \_\_\_\_\_
13. Please indicate if you had any of the following treatments done:  
 Crowns or Caps     Full or Partial Dentures     Periodontal (Gums) |  Bridgework/Orthodontic (Braces)     Root Canal
14. Are you dissatisfied with the appearance of your teeth? \_\_\_\_\_

### Privacy Consent and General Release:

Privacy of your personal information is as important part of your office as providing you with quality dental care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and as clear as possible about the way in which we handle your personal information. All our staff members who come into contact with your personal information are trained in the appropriate uses and protection of your personal information. I, the undersigned, understand that the data contained in the dental and medical history portion of this chart is important to treatment. I certify that all the information is correct and that I have not knowingly omitted data. I consent to the release of medical information my medical doctor or other health provider as is required by World Dental Clinic. I authorize World Dental Clinic to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for myself and my dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Reviewed by Dentist

\_\_\_\_\_  
Date