STEVEN M. HALL DDS **AARON S. CLARK DDS**

PATIENT REGISTRATION FORM

PATIENT_____ BIRTH DATE_____ SOCIAL SECURITY #_____

HOME ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME PHONE_____ CELL_____ EMAIL_____

EMPLOYER_____ BUSINESS PHONE_____

IN CASE OF EMERGENCY, NOTIFY_____ PHONE_____

WHO IS REPONSIBLE FOR THIS ACCOUNT?_____RELATIONSHIP TO PATIENT_____

DENTAL INSURANCE COMPANY_____GROUP NUMBER_____

IF YOUR SPOUSE HAS DENTAL INSURANCE, ARE YOU ALSO COVERED UNDER THAT POLICY? ___ SPOUSE'S SOC. SEC.#_____

WHOME MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

PATIENT REGISTRATION FORM

YES / NO ARE YOU IN GENERAL GOOD HEALTH AT THIS TIME?
YES / NO ARE YOU CURRENTLY UNDER MEDICAL TREATMENT? IF SO, FOR WHAT?_____
YES / NO HAVE YOU HAD ANY MAJOR OPERATIONS? IF SO, WHAT?_____
YES / NO HAVE YOU HAD ANY HEAD INJURIES? IF SO, WHAT?_____
YES / NO HAVE YOU HAD ANY REACTIONS TO ANY DRUGS INCLUDING PENICILLIN? IF SO, WHAT?_____
YES / NO ARE YOU NOW TAKING ANY MEDICATION? LIST MEDICATIONS:_____
_____
YES / NO DO YOU TAKE ASPIRIN DAILY?
YES / NO ARE YOU ALLERGIC TO ANY KNOWN MATERIALS RESULTING IN HIVES OR ASTHMA. IF SO, WHAT?_____
YES / NO HAVE YOU EVER BEEN PREMEDICATED FOR DENTAL TREATMENT? IF SO, WHY?_____
YES / NO WOMEN: ARE YOU PREGNANT? IF SO, HOW FAR ALONG?_____

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT:

HEART FAILURE	CANCER	SINUS TROUBLES	THYROID DISEASE
HEART PACEMAKER	RADIATION TREATMENT	ASTHMA	COLD SORES/FEVER BLISTERS
HEART MURMUR	HEPATITIS B (SERUM)	DIABETES	PAIN IN JAW JOINTS
ARTIFICIAL HEART VALVE	HEPATITIS A (INFECTIONS)	KIDNEY TROUBLE	PSYCHIATRIC TREATMENT
ANGINA PECTORIS (PAIN IN CHEST)	VENERAL DISEASE	DENTAL INPLANTS	CORTISONE (STEROIDS)
MITRAL VALVE PROLAPSE	HIV POSITIVE (AIDS)	ARTHRITIS	HYDROCEPHALUS
HIGH BLOOD PRESSURE	TUBERCULOSIS (TB)	FAINTING OR DIZZINESS	OTHER _____
STROKE	RHEUMATIC REVER	DRUG ADDICTION	_____
HEART DISEASE OR ATTACK	EMPHYSEMA	EPILEPSY OR SEIZURES	_____
HEART SURGERY	HEMOPHILIA	ARTIFICAL JOINT	_____
ARTIFICIAL VALVE	ANEMIA	ULCER	_____

PATIENT DENTAL HISTORY

DATE OF LAST DENTAL EXAM_____PREVIOUS DENTIST_____
WHAT IS YOUR REASON FOR SEEKING DENTAL CARE TODAY? _____
DO YOU SMOKE? YES / NO
HOW MANY SWEETENED DRINKS (POP, ENERGY DRINKS, TEA, COFFEE, ETC…) DO YOU DRINK A DAY? _____
HAVE YOU EXPERIENCED ANY GROWTH OR SORE SPOTS IN YOUR MOUTH? IF SO WHERE? _____
DOES ANY PART OF YOUR MOUTH HURT WHILE CHEWING? IF SO, WHERE? _____
DO YOU CHEW ON ONLY ONE SIDE OF YOUR MOUTH? IF SO, WHY? _____
ANY REACTIONS OR ALLERGIC SYMTOMS TO DENTAL ANESTHETHETIC? _____
ANY PROBLEMS WITH PROLONGED BLEEDING IN THE PAST? YES / NO
DO YOUR GUMS BLEED? YES / NO
HAVE YOU BEEN TOLD YOU HAVE GUM DISEASE (PERIODONTITIS)? YES / NO
DO YOU CLENCH OR GRIND YOUR TEETH? YES / NO NIGHT OR DAY _____
ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH? YES / NO IF NO, WHY?_____
DO YOU FEEL NERVOUS ABOUT HAVING DENTAL TREATMENT? YES / NO
HAVE YOU EVER HAD A BAD EXPERIENCE IN A DENTAL OFFICE? IF SO, WHAT?_____
HOW OFTEN DO YOU BRUSH YOUR TEETH? _____ FLOSS? _____
WHEN WAS YOUR LAST FULL MOUTH SERIES OF X-RAYS TAKEN?_____WHERE? _____

SIGNATURE_____DATE_____

Medical History Update

PLEASE REVIEW YOUR REGISTRATION AND HEALTH HISTORY FORM AND EXPLAIN ANY CHANGES.

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