DEPENDENT REGISTRATION

PATIENT'S LAST NAME	FIRST NAME	M. INITIAL	DATE OF BIRTH
STREET ADDRESS	CITY, STATE & ZIP		HOME PHONE
SEX □ MALE □ FEMALE	FULL TIME STUDENT □ YES □ NO	SOCIAL SECURITY NO.	
NEAREST RELATIVE OR FRIEND'S NAME , ADDRESS & PHONE (not at same address) □ RELATIVE □ FRIEND			

PERSON RESPONSIBLE FOR THIS ACCOUNT

RESPONSIBLE PARTY LAST NAME	FIRST NAME	M. INITIAL	DATE OF BIRTH
STREET ADDRESS	CITY, STATE & ZIP		HOME PHONE
EMAIL ADDRESS	SOCIAL SECURITY NO	DRIVERS LICENSE NO.	WORK PHONE
EMPLOYED BY	MARITAL STATUS □ SINGLE □ MARRIED □ SEPARATED □ DIVORCED □ WIDOWED		CELL PHONE
BUSINESS ADDRESS	HOW LONG EMPLOYED □ HOURLY □ SALARY □ RETIRED		

OTHER PARENT/GUARDIAN LAST NAME	FIRST NAME	M. INITIAL	DATE OF BIRTH
STREET ADDRESS	CITY, STATE & ZIP		HOME PHONE
EMAIL ADDRESS	SOCIAL SECURITY NO	DRIVERS LICENSE NO.	WORK PHONE
EMPLOYED BY	MARITAL STATUS □ SINGLE □ MARRIED □ SEPARATED □ DIVORCED □ WIDOWED		CELL PHONE
BUSINESS ADDRESS	HOW LONG EMPLOYED □ HOURLY □ SALARY □ RETIRED		

PRIMARY DENTAL INSURANCE CO.		MAILING ADDRESS	
GROUP #	SERVICE CODE	CONTRACT ID/ S.S. NO.	INS. CO. PHONE NO.

SECONDARY DENTAL INSURANCE CO.		MAILING ADDRESS	
GROUP #	SERVICE CODE	CONTRACT ID/ S.S. NO.	INS. CO. PHONE NO.

HEALTH HISTORY

Patient Name: ______________________ Date of Birth: ______________________

I. CIRCLE APPROPRIATE ANSWER

YES NO Is your general health good?
YES NO Has there been a change in your health within the last year?
YES NO Have you been hospitalized or had a serious illness in the last three years?
If YES, explain? ______________________
YES NO Are you being treated by a physician now? For what? ______________________
Physician's Name and Phone No. ______________________
YES NO Date of last Dental Exam ______________________
YES NO Are you in pain now? If YES, please explain ______________________

II. DO YOU HAVE OR HAVE YOU HAD: (If yes, please indicate by circling appropriate answer)

YES NO Heart disease, heart attack, pacemaker, prosthetic heart valve, or heart murmur?
If YES, please explain ______________________
Treating Physician's Name & Phone No. ______________________
YES NO Rheumatic fever?
YES NO Stroke, hardening of arteries?
YES NO High blood pressure?
YES NO Asthma, TB, emphysema, other lung disease?
YES NO Hepatitis, other liver disease?
YES NO Diabetes
YES NO Psychiatric care?
YES NO Tumors, cancer?
YES NO Radiation treatments or Chemotherapy?
YES NO Allergies to: **drugs, food, medications, latex, nickel**
If YES please list: ______________________

YES NO Anemia?
YES NO VD (syphilis/gonorrhea)?
YES NO Herpes?
YES NO Kidney, bladder disease?
YES NO Thyroid, adrenal disease?
YES NO HIV/AIDS?
YES NO Blood transfusions?
YES NO Osteoporosis?
YES NO Arthritis, rheumatism?
YES NO Artificial joint?

III. ARE YOU TAKING:

YES NO Tobacco in any forms?
If Yes, how much ______________________
YES NO Drugs, medications, over-the-counter medicines (including aspirin), natural remedies?
Please list: ______________________
____

YES NO Alcohol?
If Yes, how often ______________________
YES NO Recreational Drugs?

IV. WOMEN ONLY:

YES NO Are you or could you be pregnant or nursing?
YES NO Taking birth control pills?

V. ALL PATIENTS:

YES NO Is there anything else you think we should be aware of?
If Yes, please explain: ______________________

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient Signature: ______________________ Date: ______________________

Patient Signature: ______________________ Date: ______________________

Patient Signature: ______________________ Date: ______________________

Patient Signature: ______________________ Date: ______________________

Patient Signature: ______________________ Date: ______________________

Patient Signature: ______________________ Date: ______________________

HEADACHE AND FACIAL PAIN SCREENING QUESTIONNAIRE

Name: ______________________ **Date:** ______________________

Temporomandibular Disorders are a frequent cause of headaches, facial pain and dental pain.
Please complete this screening questionnaire.

SYMPTOM CHECKLIST: Please check any of the following symptoms that apply to you. (L=left and R=right)

Headaches:

_______ Migraines _______ Tension Headaches _______ Other ______________________

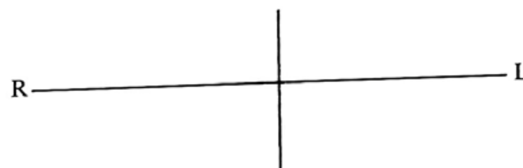
How often? ______________________

	L	R
Top of Head	_______ L	_______ R
Forehead	_______ L	_______ R
Back of Head	_______ L	_______ R
Pain in Head	_______ L	_______ R
Pain in Ear	_______ L	_______ R
Dizziness (vertigo)	_______ L	_______ R
Pain in Jaw Joint	_______ L	_______ R
Temples	_______ L	_______ R
Behind Eyes	_______ L	_______ R
Pain in Shoulder	_______ L	_______ R
Ear Congestion	_______ L	_______ R
Tinnitus (ringing in ears)	_______ L	_______ R
Facial Pain (non-specific)	_______ L	_______ R
Grating sound in joint	_______ L	_______ R

Clicking or popping in jaw joint _______ L _______ R

Partial inability to open mouth _______ No _______ Yes _______ Constant _______ Sporadic

Face muscle twitch _______ No _______ Yes



Difficulty swallowing _______ No _______ Yes

Difficulty breathing through nose _______ No _______ Yes

Difficulty chewing _______ No _______ Yes

Have you ever worn braces _______ No _______ Yes

Age when braces were on ______________________

Orthodontist ______________________

SLEEP APNEA EVALUATION

We have seen a recent increase of sleep apnea findings in our patients, which is a life threatening medical problem. To protect your health, we are asking you to complete the following screening form.

PLEASE ANSWER:

$$BMI = \frac{W}{H^2_{(in)}} \times 703 = ______$$

Do you snore? _______ No _______ Yes

Are you excessively tired during the day? _______ No _______ Yes

Have you been told you stop breathing during sleep? _______ No _______ Yes

Do you have a history of hypertension? _______ No _______ Yes

Is your neck size greater than.......
17 inches (male)
16 inches (female) _______ No _______ Yes

YES to two or more of these questions is a positive screen for sleep apnea. If you answered yes to two or more questions, show this completed questionnaire to your doctor.