REGISTRATION AND HEALTH HISTORY

Name: ______________________ Social Security #: ______________________
Name we should call you: ______________ Date of Birth: ______________________
Home Phone #: ______________Cell #: ____________ E-mail Address: ______________
Address: ____
Employed By:____
Position: ______________________ Work Phone# ______________________
Marital Status: __________ Spouse's Name: ______________________________
Spouse's SS#: ________________ Spouse's Date of Birth: ______________________
Spouse Employed By: ____
Position: ______________________ Work Phone# ______________________
Nearest Relative (In case of emergency): ______________________________
Phone #: ________________ City & State: ______________________
Who may we thank for referring you to our practice? ______________________
Who will pay your account? ______________________________________
Purpose of this visit: ______________________________________

INSURANCE INFORMATION:

Name of Primary Dental Insurance Company: ______________________________
Name of Employee/Policy Holder: ______________________ Group #: ______________
Member/Subscriber/Employee # (If Applicable) ______________________________

MEDICAL HISTORY:

Name & phone # of Primary Care Physician: ______________________________
Date of your last complete physical: ______________________________________
Are you taking any medication, pills, drugs, vitamins or supplements now? __________ If so, list them below:

Name of Medication/Drug/Supplement:	Purpose/Reason:
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

DENTAL HISTORY:

Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? _____
How long since you have been to a dentist? ____________________
What was done then? ____________________
Are you having any discomfort at this time? __________ If so, explain: ____________________
____
Have you lost any teeth? ________ How many? ________ Why? ____________________
Have they ever been replaced? ____________________
Are your teeth sensitive to heat? __________ To cold? __________ To sweets? __________
Have you had your teeth straightened? _________ When? ____________________
How often do you brush your teeth? ____________________
What texture toothbrush do you use? ____________________
Do you use an electric toothbrush? ____________________
Do you use a water jet? ____________________
Do you use dental floss? ____________________
Do your gums often feel tender or swollen? _________ Where? ____________________
Do your gums bleed frequently? ________ When?____________________
Do you think you take good care of your teeth? ____________________
Does food wedge between your teeth? ________ Where? ____________________
Do you feel like you have bad breath? ____________________
Do you have an unpleasant taste in your mouth? ____________________
Have you ever had gum treatments? _________ When? ____________________
Do your jaws ever feel tired? ____________ When? ____________________
Do you grind or clench your teeth? _________ When? ____________________
Do you have any pain in or around your ears? ____________________
Do you hear popping, clicking or snapping noises when you chew?____________________
Do you experience any chewing difficulty? ____________________
Do you have any nasal obstruction? ____________________
Are you aware of any swelling or lumps in your mouth? ____________________
Do you usually have many cavities? ____________________
Do you have any fear or anxiety associated with dentistry? __________ If so, explain _________
____
Do you like your smile? __________ If not, why: ____________________
Do you have any disease, condition or problem not previously listed? If so, explain__________
____

Date: __________________ Signature: ____________________

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS. I AUTHORIZE BENEFITS TO BE PAID TO F. EUGENE GRUBB, JR., D.D.S. / STEVEN L. HATCHER, D.D.S., PA. I AGREE THAT THIS AUTHORIZATION SHALL BE VALID UNTIL RESCINDED IN WRITING OR REPLACED BY ONE OF A LATER DATE.

Date: __________________ Signature: ____________________