Date : _____________

REGISTRATION AND HEALTH HISTORY

Name: ____________________________________ Social Security #: ________________

Name we should call you: _____________________ Date of Birth:_____________________

Home Phone #: ______________Cell #: _____________ E-mail Address: _______________

Address: __________________________________City/State/Zip____________________

Employed By:_______________________ Driver's Lic # and State Issued _______________

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:_____________________________________

Employer that Carries Insurance: ____

Address of Primary Dental Insurance Co: _______________________________________

Name of Employee/Policy Holder: ____________________________DOB: ____________

Member/Subscriber/Employee ID # (If Applicable) ______________Group #: ___________

MEDICAL HISTORY:

Name & phone # of Primary Care Physician: ______________________________________

Date of your last complete physical: ____

Please Complete the Separate MEDICAL HISTORY FORM

Initial Visit Interview

- ❑ Dr.
- ❑ Mr.
- ❑ Mrs.
- ❑ Miss
- ❑ Ms.____ Date ________________

Last First Middle Initial

Your answers to this dental history questionnaire will help us understand your specific dental problems, so that we may effectively treat you with consideration for your individual needs.

Previous Dentist ________________________________ Specialty __________________

Period of Treatment ___________________________ Date of Last Visit _____________

Address ____

Number Street City State Zip Code (area code) Phone

What is your immediate dental concern? ______________________________________

____

Please check YES or NO (or circle one).

1) I think I am:
   - ❑ In Excellent oral health.
   - ❑ In Good oral health.
   - ❑ In Poor oral health.

2) I desire:
   - ❑ Excellent oral health.
   - ❑ Average or Good oral health.
   - ❑ Crisis Care only.

3) Are you presently in pain? **YES** or **NO**
   - ❑ Teeth
   - ❑ Gums
   - ❑ Jaw
   - ❑ Face
   - ❑ Other _________________________

4) Is any part of your mouth sensitive to the following? **YES** or **NO**
   - ❑ Hot
   - ❑ Cold
   - ❑ Sweet
   - ❑ Sour
   - ❑ Pressure
   - ❑ Other _________________________

5) Do you have a burning sensation in your mouth? **YES** or **NO**
6) Are you troubled with dryness in your mouth? **YES** or **NO**
7) Do you have any pain or soreness around your ears, cheeks, or other parts of your face? **YES** or **NO**
8) Do you have chronic headaches? **YES** or **NO**
9) Have you ever had periodontal treatment or gum surgery? **YES** or **NO**
   If Yes, when? ___________________ By Whom? ____________________________
10) Have you ever been informed of any gum problems? **YES** or **NO**
   If Yes, when? ___________________ By Whom? ____________________________
11) Do your gums bleed when you brush your teeth? **YES** or **NO**
12) Does food catch between your teeth? **YES** or **NO**
13) Do you drink sodas/pop? **YES** or **NO**
14) Are you aware of a bad taste or odor in your mouth? **YES** or **NO**
15) Please indicate which items you use daily.
   - ❑ Hard-bristle toothbrush
   - ❑ Soft-bristle toothbrush
   - ❑ Electric toothbrush
   - ❑ Proxi-brush
   - ❑ Rubber Tip
   - ❑ Dental Floss
   - ❑ Water Spray
   - ❑ Stimudents or toothpicks
   - ❑ Other ____
16) Are you aware of any growths or swelling in your mouth? **YES** or **NO**
   If Yes, Where are they located and how long have they existed? ________________
   ____
17) Do you have frequent cold sores, canker sores, or fever blisters on your gums, cheeks or lips? **YES** or **NO** If Yes, how often? _________________________________
18) Are you aware of your jaw clicking, popping, or making grating-like noises? **YES** or **NO** If Yes, when? ____
19) Do your jaw muscles feel tired, stiff or painful? **YES** or **NO**
20) Do you chew gum? **YES** or **NO**
21) Are you aware of clenching your teeth during the day? **YES** or **NO** If Yes, how often?
   ____
22) Have you ever been told that you grind your teeth during your sleep? **YES** or **NO** If Yes, how often? ____
23) Do you wear a removable denture or appliance? **YES** or **NO** If Yes, when do you wear it? ____
24) Are you frustrated by needing constant dental repair because of active dental disease? **YES** or **NO**
25) Are you anxious about dental treatment? **YES** or **NO**
26) Do you have any disease or known condition which has not been addressed in the above. That you feel is important for us to know? If Yes, please explain: __________
   ____

27) My mouth is:
- ❑ Very Comfortable.
- ❑ Moderately Comfortable.
- ❑ Uncomfortable.

28) I:
- ❑ Think the appearance of my mouth is excellent.
- ❑ Think the appearance of my mouth is adequate.
- ❑ Wish I could change the appearance of my mouth.
  If so, what would you change? ____
  ____

29) I:
- ❑ Want to save my teeth at all costs.
- ❑ Prefer to keep my teeth if cost and time are reasonable.
- ❑ Am not very interested in setting personal goals to achieve optimum oral health.

30) I:
- ❑ Have followed the recommendations for optimum dental health given by my dentist.
- ❑ Have not done what dentists recommended I do with my mouth.
- ❑ Usually only go to the dentist for emergencies.

31) What are some questions about dentistry and your oral health that you have never had adequately answered? ____
____
____

As it relates to my medical history, all of the preceding answers are true and correct to the best of my knowledge. If I ever have a change in my health, or if my medications change, I will inform Dr. Hatcher or his staff at my next dental appointment without fail. (Insurance patients only: I authorize release of any information relating to dental insurance claims.) I understand that I am responsible for all costs of dental treatment and that before credit is extended, a credit report will be obtained.

Signature ____ Date ______________