LONG ISLAND DENTAL EXCELLENCE

REGISTRATION AND HEALTH HISTORY

Name _____ Birth date _____ Age _____

Address _____ Single ____ Married ____ Divorced ____ Widowed _____

_____ Zip _____ ***How did you hear about our office?*** _____

_____

Home Phone _____

Cell Phone _____ Social Security # _____

Email _____ Occupation _____

Do you have dental insurance? **YES** **NO** Employer _____

If so, insurance co? _____ ID # _____ Business Phone _____

It is important that we know about your dental and medical history. Many conditions and medications have a direct bearing on your oral health. We will review the questionnaire and discuss it with you. Information which you give us is strictly confidential and will not be released to anyone without your permission.

General Health (check one): Excellent _____ Good _____ Fair _____ Poor _____

Date of Last Physical Examination: _____

Name and Address of Physician: _____

_____ Phone _____

YES NO Are you now under the care of a physician?
If so, what is the condition being treated? _____

YES NO Have you had any serious illness or operation?
If so, what illness or operation? _____

YES NO Have you been hospitalized or had a serious illness in the past 5 years?
If so, what was the problem? _____

YES NO Have you ever had a blood transfusion?
When? _____

Please list ALL MEDICATIONS currently in use: (Specify amounts each day)

Please indicate any personal history of the following:

____ Allergies to medications
- ____ Penicillin
- ____ Aspirin
- ____ Codeine, Valium or other sedatives
- ____ Novocaine or other local anesthetics
- ____ Sulfa Drugs
- ____ Other: _____

____ Allergy to LATEX

____ High Blood Pressure usual or last BP
____ Low Blood Pressure _____ / _____

____ Heart Murmur
____ Heart Disease
- ____ Heart Attack? When? _____
- ____ Angina
- ____ Mitral Valve Prolapse
- ____ Open Heart Surgery
  Type? _____
- ____ Rheumatic Heart Disease or Fever
- ____ Prosthetic Heart Valve
- ____ Congenital Heart Lesion
- ____ Other: _____

PLEASE CONTINUE ON THE OTHER SIDE

Please indicate any personal history of the following:

____ Bleeding disorder
____ Prolonged bleeding from extractions, surgery or trauma
____ Diabetes
____ Excessive urination and/or thirst
____ Anemia
____ Circulation problems
____ Stroke; when?_____
____ Dizziness or fainting spells
____ Headaches
____ Epilepsy
____ Seizures or convulsions
____ Cancer or Malignancy; status _____
____ Benign tumors or growths
____ Chemotherapy
____ Radiation therapy
____ Stomach/Gastrointestinal disorder
____ Ulcers
____ Kidney disease
____ Liver disease
____ Hepatitis or jaundice: Type _____
Date _____
Current status _____
____ Venereal disease
____ Herpes
____ Asthma
____ Persistent cough
____ Tuberculosis
____ Sinus problems
____ Eye Problems or Glaucoma
____ Do you wear contact lenses?
____ Hearing problems
____ Arthritis
____ Cerebral Palsy
____ Multiple Sclerosis
____ HIV/AIDS
____ Joint replacement
____ Latex sensitivity
____ Other: _____

YES NO Are you pregnant? What month? _____ If no, are you planning a pregnancy in the near future? _____
YES NO Do you have any problems with your menstrual period?
YES NO Are you nursing?
YES NO Are you taking Birth Control Pills?
YES NO Are you a smoker? If so, how much do you smoke per day? _____
YES NO Do you consume alcohol? If so, how much do you consume per week? _____
YES NO Are you taking Tagamet (Cimetidine?) If yes, how often? _____
YES NO Do you take Antacids? If yes, how often? _____
YES NO Are you taking any herbal supplements/medicines? If yes, which ones? _____
YES NO Are you on a restricted diet? If so, how many meals per day? _____
YES NO Do you have any food allergies? If so, to what? _____
How much sugar is in your diet? _____ None _____ Slight ____ Moderate _____ High
YES NO Do you consume grapefruit juice, grapefruit or grapefruit extract?

Reason for this visit: _____
Previous Dentist: _____
Date of last visit? _____
Reason for leaving? _____
YES NO Have you had any serious problem associated with previous dental treatment?
If so, please explain: _____
YES NO Have you ever had a serious injury to your face, head or teeth?
If so, please explain: _____
YES NO Are you experiencing pain in any part of your mouth?
YES NO Are any of your teeth sensitive to hot, cold or sweets?
YES NO Do your gums bleed?
YES NO Does your jaw “click” or “pop”?
YES NO Do you grind your teeth while sleeping or during the day?
YES NO Have you ever had TMJ (jaw joint) problems?
YES NO Have you ever had radiation treatments to your face, head or neck?
YES NO Do you gag easily?
YES NO Are you familiar with the term “Preventive Dentistry”?
YES NO Do you feel you have bad breath?
YES NO ARE YOU HAPPY ABOUT THE APPEARANCE OF YOUR SMILE?
If no, what concerns about your smile would you like us to address? _____

_____

_____

Please add anything else that you feel is important: _____

_____

Patient Signature _____ Date _____