HEALTH HISTORY AND PATIENT REGISTRATION FORM
IMPLANT DENTISTRY OF GREATER LANSING

Date ______________________________

Name ____ Please check one: Mr. Mrs. Ms. Miss Dr.

Address ____City ____________________ State ______ Zip ____________

Previous address if less than 3 years ______________________City ____________________ State ______ Zip ____________

Phone: Home (______) _______ - ________ Work (______) _______ - ________ Cell (______) _______ - _________

E-mail Address: ____________________________________ Birthdate _________________ Age _________ Sex: F M

Please check one: single married widowed separated divorced

Place of employment ______________________________occupation _______________________ How long employed _______

Address of employment ____

Social Security # _____________________________ Insurance Contract # _________________________

IF MARRIED

Spouse's Name ___________________ Birthdate ________________ Social Security # _______________

Referred by: Doctor: _____________________________ Patient: ___________________________________

Yellow pages Advertisement Newspaper Radio

Nearest Neighbor or Relative's Name, Address and Phone No. _____________________________________

INSURANCE INFORMATION

Primary Insurance Coverage ____________ Second Insurance Coverage ______________

Insured's Name ______________________ Insured's Name ________________________

Insurance Co. _________________________ Insurance Co. _________________________

Insurance Co. Address ________________ Insurance Co. Address __________________

Insured's Employer ____________________Insured's Employer _____________________

Group or Policy # ______________________ Group or Policy # _______________________

Type of Insurance Dental Type of Insurance Dental

Name of Previous Dentist ______________________ Last visit _______________________________

MEDICAL HISTORY

For the following questions, check yes or no, whichever applies. Your answers are for our records only and will be considered confidential. These facts have a direct bearing on your dental health.

1. Are you in good health? . . . . YES NO
2. Has there been any change in your general health within the year?. . . . . YES NO
3. My last physical examination was on ____
4. Are you now under a physicians care? . . . . YES NO

   If so, for what condition are you being treated ____
5. The name and address of your physician is ____
6. Have you had any serious illness or operation? . . . . YES NO

   If so, what was the illness or operation ____
7. Have you been hospitalized or had a serious illness with in the last 5 years?. . . . . YES NO
8. Have you had any history of Tumors, Malignancies or treatment of cancer, of any nature? . . . . YES NO
9. Do you have or have you ever had any of the following:
   A. Rheumatic fever or Rheumatic heart disease? .YES NO
   B. Congenital heart disease? . . . . YES NO
   C. Heart Murmur? . . . . YES NO
   D. Allergy? .YES NO
   E. Asthma or hay fever? . . . . YES NO
   F. Sinus Trouble? . . . . YES NO
   G. Hives or skin rash? .YES NO

H. Fainting spells or seizures? . . . . YES NO
I. Epilepsy? . . . . YES NO
J. Hepatitis, Jaundice or Liver disease?. . . . . YES NO
K. Arthritis? . . . . YES NO
L. Have you ever been tested for HIV virus . . . . YES NO
Results: __________negative ___________positive
M. Inflammatory rheumatism? . . . . YES NO
N. Stomach Ulcers. . . . . YES NO
O. Cardiovascular disease, Heart disease:
(heart trouble, heart attack, stroke, coronary insufficiency, coronary damaged heart valves, heart murmur, artificial heart valve, Mitral valve prolapse, heart surgery, etc.). . . . . YES NO
P. Kidney Trouble? . . . . YES NO
Q. Do you have a persistent cough or cold? . . . . YES NO
R. Diabetes? . . . . YES NO
Do you have to urinate more than six times a day?. . . . . YES NO
Are you thirsty much of the time?. . . . . YES NO
Does your mouth feel frequently dry?. . . . . YES NO
S. Low Blood Pressure? . . . . YES NO
T. Tuberculosis . . . . YES NO
U. Venereal Disease? (Syphilis, Gonorrhea, etc) . . . . YES NO
V. Sickle Cell Disease? . . . . YES NO
W. Other ____
X. Cancer of chemotherapy, or radiation treatment, Leukemia?. . . . . YES NO
Y. Glaucoma (open, closed angle) . . . . YES NO
Z. Night sweats . . . . YES NO

10. Have you had an artificial hip, knee or other replacement surgery?. . . . . YES NO
11. Have you had abnormal bleeding associated with any previous surgery, extraction or trauma? . . . . YES NO
12. Do you have any blood disorder(s)? Anemia? . . . . YES NO
Any family history of bleeding disorders? . . . . YES NO
13. Are you taking any medicine? . . . . YES NO
If so, what ____
14. Do you smoke? . . . . YES NO
15. Do you chew tobacco? . . . . YES NO
16. Are you taking any of the following? If yes, please list name.
Antibiotic or sulfa drugs? . . . . YES NO
Anticoagulant? . . . . YES NO
Medicine for high blood pressure? . . . . YES NO
Tranquilizers? . . . . YES NO
Cortisone, steriods?. . . . . YES NO
Aspirin? . . . . YES NO
Antihistamines? . . . . YES NO
Insulin, tolbutamide, orinase or similar drug . . . . YES NO
Digitalis or drugs for heart disease? . . . . YES NO
Nitroglycerin?. . . . . YES NO
Other ____
17. Are you allergic to or have your reacted adversely to:
Local Anesthetics?. . . . . YES NO
Penicillin or other antibiotics . . . . YES NO
Sulfa Drugs? . . . . YES NO
Barbiturates, sedatives, or sleeping pills? . . . . YES NO
Aspirin? . . . . YES NO
Iodine? . . . . YES NO
Codeine or other narcotics? . . . . YES NO
Other ____
18. Do you have any disease, condition, or problem not listed above that you think we should know about?
19. Are you employed in a position which exposes you regularly to x-rays or any other ionizing radiation? YES NO
20. Are you wearing contact lenses? . . . . YES NO

DENTAL HISTORY

1. What is your chief dental complaint?

   ____

   ____

2. Please give a brief dental history of this problem

   ____

   ____

3. Are you satisfied with the appearance of your teeth? . . . . YES NO
4. Are you able to eat and chew food satisfactorily?. . . . . YES NO
5. Are you experiencing any discomfort or pain at this time? . . . . YES NO
6. Do you have headaches, earaches, or neck pain? . . . . YES NO
7. Do you frequently experience sinus problems? . . . . .YES NO
8. Have you had any serious trouble associated with any previous dental treatment? . . . . .YES NO
   If yes, please explain ____

WOMEN

1. Are you pregnant? . . . . .YES NO
2. Are you taking oral contraceptives or hormonal therapy?. . . . . YES NO
3. Are you Nursing?. . . . . YES NO

   Please rank the following in order of which they would keep you from having dental treatment.

4. # ______ FEAR of pain, surgery, injections.
5. # ______ FEE for treatment.
6. # ______ TIME off work.
7. # ______ RESULTS expected.
8. # ______ NOCONCERNS.

RESPONSIBILITY AND CONSENT STATEMENT

I hereby authorize and request the performance of dental services for myself or for:

____

I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purposed or dental treatment.
(Such as study models, photographs, and x-rays.)

I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage. Treatment plans involving extended credit circumstances may have a credit check done on my credit rating.

____ ____________________________

(signature of patient) (date)