W. Randy Weber D.D.S. *Doctor of Dental Surgery*
ADULT REGISTRATION & HEALTH HISTORY QUESTIONNAIRE

Patient's Name_____ Today's Date_____

Name (Husband or Wife) _____

Home Address _____ City_____ Zip_____

Home Phone # _____Cell Phone #_____

Business Phone # _____ What phone number can you be reached to confirm appointments?_____

Your Age_____Birthdate _____ Can We Leave A Message? YES / NO _____

Social Security Number _____

What is your occupation?_____ Employer_____

Do you have a Dental Assistant Plan? _____ Name of Dental Insurance Co. _____

Do you have children at home? _____ Age(s)_____

In case of an emergency who should we contact? _____ Phone: _____

Who Referred You?_____ **How Did You Find Out About Our Office?**_____

DENTAL HEALTH HISTORY. . .

1. Date of last dental treatment?_____
2. Name and address of previous Dentist?_____
3. What was the last appointment for? _____
4. Reason for this appointment?_____
5. Have you had problems with dental treatment? _____Explain. _____
6. What can we do to make your visit a pleasant one?_____
7. Do you have any pain in your teeth because of heat, cold, sweets, or chewing?_____
8. Do your gums bleed, or feel tender, either when chewing or brushing or at any other time? _____
9. Are you aware you can have gum disease and bone destruction without pain?_____
10. Are you aware of clenching your teeth? _____
11. Do you have headaches, neck tension, tired jaws or ear problems? _____
12. Do you feel you have mouth odor? _____
13. Have you been shown how to do proper bacterial reduction for your mouth by:_____
14. How often do you brush daily?_____ How many days a week do you floss?_____Do you use a Water Pic?_____
15. If you could, what would you change about your smile?_____
16. Would you be interested in making your teeth whiter?_____
17. Is snoring a problem for you? Yes____ No____ Snoring is a treatable dental problem.
18. How often do you have your teeth and gums cleaned? Every_____ months.

-Turn Over-

ADULT MEDICAL HEALTH HISTORY . . . Name _____ YOUR AGE _____

General Health (Please Check): _____ Excellent _____ Good _____ Fair _____ Poor

1. Have you been a patient in the hospital during the past two years? What for? _____ YES NO

2. Have you been under the care of a medical doctor during the past two years? What for? _____ YES NO

3. Are you taking medicine now? What? _____ YES NO

_____

4. Are you allergic to (i.e. Itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? _____ YES NO

5. Have you ever had any excessive bleeding requiring special treatment? _____ YES NO

6. Circle any of the following which you have had or have at present:

Allergies or Hives
Anemia
Angina
Anxiety Treatment
Arthritis
Artificial Heart Valve
Artificial Joint
Asthma
Blood Transfusion
Bruise Easily
Chemotherapy (Cancer, Leukemia)
Cold Sores
Congenital Heart Lesions
Cortisone Medicine
Depression
Diabetes
Drug Addiction
Emphysema
Epilepsy or Seizures
Fainting or Dizzy Spells
Glaucoma
Heart Disease or Attack
Heart Failure
Heart Murmur
Heart Pacemaker
Heart Surgery
Hearing Problems
Hemophilia
Hepatitis A (infectious)
Hepatitis B (serum)
Hepatitis C
High Blood Pressure
HIV
Kidney Trouble
Latex Allergy
Liver Disease
Nervousness
Osteoporosis
Pain in Jaw Joints
Rheumatic Fever
Rheumatoid Arthritis
Scarlet Fever
Sickle Cell Disease
Sinus Trouble
Stroke
Thyroid Disease
Tuberculosis (TB)
Ulcers
X-Ray or Cobalt Treatment

Name of Physician: _____ Location (City) _____

7. Are you taking medication for osteoporosis? Fosimax, Boniva, etc. _____ YES NO

8. When you walk up stairs, do you get shortness of breath or pain in your chest? _____ YES NO

9. Has your medical doctor ever said you have a cancer or tumor? _____ YES NO

10. Do you have any disease, condition, or problem not listed? _____ YES NO

11. Do you smoke? YES _____ NO _____ Do you use chewing tobacco? _____ YES NO

12. Do you consume alcohol? NO _____ Seldom _____ 1 or 2 Drinks Daily _____ More _____ YES NO

13. Have you had a drug addiction or recreational drug use? _____ YES NO

14. WOMEN: Are you pregnant now? _____ YES NO

Are you taking birth control pills? _____ YES NO

Do you anticipate becoming pregnant? _____ YES NO

AUTHORITY FOR TREATMENT:

Consent: I acknowledge that the above information is correct, I hereby consent to and authorize the doctor to perform any and all forms of treatment, medication, therapy and patient management techniques that may be indicated in connection with the dental care of the patient. I understand that my dental insurance carrier will pay less than the actual bill for services; I agree to arrange to pay for all services rendered by this office the day of service. Remaining balance after insurance pays will be placed on your credit card, debit card or checking account. A late charge of 1.5% on the balance then unpaid and owed will be assessed each month. **In the case of default on payment of the account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this account.** I understand that where appropriate, credit bureau reports may be obtained to offer financing for the services. Please circle method of payment for services not covered by insurance: Credit Card Debit Card Check Cash

Signature of Patient or Guardian _____

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