Amber P. Lawson, DMD
Dental Registration and Health History

Date: _____

Patient's Name_____ How do you prefer to be addressed? _____

Mailing Address _____ City _____ State _____ Zip _____

Sex: M ☐ F ☐ Age: _____Birth date: _____ ☐ Single ☐ Married ☐ Widow ☐ Separated ☐ Divorced SS#_____

Home Phone Number: _____ Cell Phone Number: _____ Work Phone Number: _____

Email Address: _____ How do you prefer to be contacted: Phone ☐ Text Message ☐ E Mail ☐

Occupation: _____ Employer: _____

Employer's Address: _____ City _____ State _____ Zip _____

If Student, Name of School/College: _____City _____ State _____ PT ☐ Fulltime ☐

Whom may we thank for referring you to our office? _____

If the person responsible for this patient's account is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section titled "Insurance Information."

Name of responsible party _____ Relationship to Patient _____

Mailing Address _____ City _____ State _____ Zip _____

Sex: M ☐ F ☐ Age: _____Birth date: _____ ☐ Single ☐ Married ☐ Widow ☐ Separated ☐ Divorced SS# _____

Home Phone Number: _____ Cell Phone Number: _____ Work Phone Number: _____

Occupation: _____ Employer: _____

Employer's Address: _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Policy Holder's Name: _____ Relationship to Patient _____ SS # _____ DOB _____

Name of Employer _____ ID # _____

Insurance Co. _____ Group # _____ Address _____

SECONDARY INSURANCE INFORMATION

Policy Holder's Name: _____ Relationship to Patient _____ SS # _____ DOB _____

Name of Employer _____ ID # _____

Insurance Co. _____ Group # _____ Address _____

Answers to the following questions are for our records only and will be considered confidential.

1. Have you or any member of your family been seen by us before? Yes ☐ No ☐
   If yes, which family member (s)? _____
2. Date of last physical examination _____ Physician's Name _____
3. Date of last dental examination _____ Date of last Dental x-rays _____
4. Previous Dentist's name _____ City/State _____
5. Are you having pain or discomfort at this time? Yes ☐ No ☐
6. Do you feel nervous about having dental treatment? Yes ☐ No ☐
7. Have you ever had a bad experience in a dental office? Yes ☐ No ☐
8. Is there anything you dislike about your smile? Yes ☐ No ☐
9. Is there anything you would like to speak with the Doctor about in private? Yes ☐ No ☐
10. Have you been a patient in the hospital during the past two years? Yes ☐ No ☐
11. Have you been under the care of a medical doctor during the past two years? Yes ☐ No ☐
12. Have you taken any medication or drugs in the past two years? Yes ☐ No ☐
13. Have you ever had any excessive bleeding requiring special treatment? Yes ☐ No ☐

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Metals

Other: _____

MEDICATIONS

Please list medications you are currently taking:

_____

_____

_____

Preferred Pharmacy_____

Please indicate by checking the box if you have had any of the following:

- ☐ Chest Pain
- ☐ Heart Failure
- ☐ Heart Disease or Attack
- ☐ Angina Pectoris
- ☐ Heart Problem
- ☐ Liver Disease
- ☐ Heart Surgery
- ☐ High Blood Pressure
- ☐ *Heart Murmur
- ☐ *Rheumatic Fever
- ☐ Psychiatric treatment
- ☐ Sickle Cell Disease
- ☐ Sinus trouble
- ☐ *Artificial joints
- ☐ Thyroid Disease
- ☐ Anemia
- ☐ Blood transfusion
- ☐ *Any type of transplant
- ☐ *Mitral Valve Prolapse
- ☐ Shortness of Breath
- ☐ Ulcers
- ☐ Mental Handicap
- ☐ Emphysema
- ☐ Fainting or dizzy spells
- ☐ Eating Disorder
- ☐ Epilepsy or seizures
- ☐ Persistent Cough
- ☐ Tuberculosis (TB)
- ☐ Asthma
- ☐ *Congenital Heart Problems
- ☐ Hepatitis A (Infectious)
- ☐ Hepatitis B (Serum)
- ☐ Hepatitis C or other
- ☐ Heart Pacemaker
- ☐ Stroke
- ☐ Drug addiction
- ☐ Cold Sores
- ☐ Radiation Therapy
- ☐ Hives or skin rash
- ☐ Alcoholism
- ☐ Herpes
- ☐ Glaucoma
- ☐ *Steroid Treatment
- ☐ Arthritis
- ☐ *Any type of implant
- ☐ Dentures or Partials
- ☐ Birth defects
- ☐ HIV Positive, ARC, AIDS
- ☐ Hay fever
- ☐ Use of tobacco products
- ☐ Bruise easily
- ☐ Jaundice
- ☐ Kidney Trouble
- ☐ Hemophilia
- ☐ Diabetes
- ☐ Chemotherapy
- ☐ Cancer(type):_____

***Antibiotic pre-medication may be required prior to your appointment.**

Have you ever experienced any of the following problems with your jaw: Check all that apply

- ☐ Clicking
- ☐ Pain in or around your ears
- ☐ Difficulty opening or closing
- ☐ Difficulty chewing
- ☐ Do you have a history of trauma to your jaw?
- ☐ Have you ever been diagnosed with TMJ/TMD?
- ☐ Do you have any sores, lumps or growth in or near your mouth?
- ☐ Have you ever had a difficult extraction in the past?
- ☐ Do you habitually clench or grind your teeth during the day or night?
- ☐ Have you ever needed to see a periodontist?
- ☐ Do you now have bleeding gums or any other gum conditions?
- ☐ Is there anything related to your medical or dental history that you have not indicated above? If yes, please explain:

Do you currently have any problems listed below?

Please check all that apply:

- ☐ Swelling
- ☐ Bad Taste
- ☐ Bleeding Gums
- ☐ Loose Teeth

Sensitive to:

- ☐ Hot
- ☐ Cold
- ☐ Biting/pressure
- ☐ Sweets

- ☐ Problems with bad breath? (Halitosis)
- ☐ Have you ever been told you have gum problems?
- ☐ Have you ever had instruction in oral hygiene?

_____

Women: Check all that apply

- ☐ Are you pregnant now?
- ☐ Are you currently breast feeding?
- ☐ Are you taking oral contraceptives?

If so, when is your due date? _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child to third party payers and/or health practioners. I authorize and request my insurance company to pay directly to the dentist, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X

_____

Signature of patients or guardian