

# 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.**

- Have you or any member of your family been seen by us before? Yes  No   
If yes, which family member (s)? \_\_\_\_\_
- Date of last physical examination \_\_\_\_\_ Physician's Name \_\_\_\_\_
- Date of last dental examination \_\_\_\_\_ Date of last Dental x-rays \_\_\_\_\_
- Previous Dentist's name \_\_\_\_\_ City/State \_\_\_\_\_
- Are you having pain or discomfort at this time? Yes  No
- Do you feel nervous about having dental treatment? Yes  No
- Have you ever had a bad experience in a dental office? Yes  No
- Is there anything you dislike about your smile? Yes  No
- Is there anything you would like to speak with the Doctor about in private? Yes  No
- Have you been a patient in the hospital during the past two years? Yes  No
- Have you been under the care of a medical doctor during the past two years? Yes  No
- Have you taken any medication or drugs in the past two years? Yes  No
- 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:**

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