ERIKS DENTAL GROUP

REGISTRATION AND HEALTH HISTORY FORM

PERSONAL INFORMATION

☐ Married ☐ Single ☐ Widow ☐ Divorced

Name: _____ Spouse Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Please circle your preferred contact phone number

Home Phone: _____ Birth Date: _____

Cell Phone: _____ Soc. Sec. #: _____

Work Phone: _____ Employer: _____

Email: _____ Referred By: _____

IN CASE OF AN EMERGENCY, CONTACT (Specify someone who does not live in your household)

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Please list the people with whom we can share / discuss your dental records and treatment with: _____

_____

MEDICAL INFORMATION

Physician's Name: _____ Date of last physical exam: _____

Are you currently under a physician's care? IF YES Please explain why: _____

_____

Are you taking a blood thinner or aspirin? ☐ YES ☐ NO If YES, what medication and dosage? _____

_____

Are you or have you ever taken a bisphosphonate like Fosamax or Actonel? ☐ YES ☐ NO

If YES, what medication and when was the last dosage? _____

Have you ever had a serious illness or surgery? ☐ YES ☐ NO

Please list / explain: _____

Women: Are you pregnant? ☐ YES ☐ NO

Are you allergic to or have you had a reaction to any of the following? Check all that apply.

☐ Local Anesthetics ☐ Aspirin ☐ Penicillin ☐ Sulfa Drugs

☐ Iodine ☐ Latex ☐ Codeine / Narcotics ☐ Any Metals

☐ Other: _____

Do you have or have you had any of the following conditions? Check all that apply.

☐ Rheumatic Fever ☐ Blood Transfusion ☐ Kidney Disease ☐ Congenital Heart Defect

☐ Hepatitis/Liver Disease ☐ Anemia ☐ Heart Valve Replacement ☐ Hip/Knee/Shoulder Replacement

☐ Cancer/Chemo/Radiation ☐ Heart Attack/Stroke ☐ Diabetes ☐ Sinus Problems

☐ AIDS or HIV Infection ☐ High Blood Pressure ☐ Gastrointestinal Disease ☐ Hemophilia

☐ Low Blood Pressure ☐ Herpes ☐ Heart Murmur/MVP ☐ Tuberculosis (TB)

☐ Dry Mouth ☐ Thyroid Problems ☐ Osteoporosis ☐ Artificial Pins or Plates

☐ Emphysema/COPD ☐ Blood Disorder ☐ Acid Reflux ☐ Glaucoma

☐ Other: _____

Please list ALL medications being taken with dosage. If you can provide a list we can copy it and place in your records.

List any other illness and / or surgery:

List medications taken:

DENTAL INFORMATION

Previous Dentist's Name:: _____

Phone: _____ Dentist's Email: _____

If you have a dentist in another location, please provide all the above information so we can coordinate treatment: ____

When was the last dental exam / visit? _____

Are any of your teeth sensitive to hot / cold? If so, what area? _____

Reason for today's visit? _____

Do any of your teeth bother you? _____

When was the last time you saw the dentist? What was done? _____

Are you happy with the appearance of your smile? _____

Are you happy with the color of your teeth? _____

Have you ever had an injury to your face / mouth? If so, what area? _____

Anything else we should be aware of? _____

Have you ever had orthodontic treatment?	☐ YES	☐ NO
Do your gums bleed when you brush or floss?	☐ YES	☐ NO
Have you had periodontal (gum) treatments in the past?	☐ YES	☐ NO
Do you have any clicking, popping, or discomfort in the jaw?	☐ YES	☐ NO
Do you grind your teeth?	☐ YES	☐ NO
Have you ever had an injury to the face?	☐ YES	☐ NO
Do you wear dentures or partials?	☐ YES	☐ NO
Do you use tobacco: cigarettes, cigars, pipes, or chewing tobacco?	☐ YES	☐ NO

Please read and sign: The information on my intake form is correct to the best of my Knowledge. I understand that throughout treatment, I am responsible for notifying the dentist / staff of any updates to the information listed on this form. **Financial Responsibility / Assignment of Benefits:** I understand that I am financially responsible for all the services rendered in this office and will give the necessary information to the office staff so they are able to submit claims on my behalf. I understand that there are only select insurance companies that this practice accepts and I am responsible for any copay or unpaid balance that is not covered.

Patient / Guardian Signature: _____ Date: _____