JEFFREY S. THALLER, DMD
General Dentistry

HEALTH HISTORY & REGISTRATION

PATIENT NUMBER A B C

PATIENT INFORMATION

PATIENT'S NAME: Last First Middle Initial

SEX: M F **BIRTHDATE** Month Date Year **AGE** **TODAY'S DATE**

IF PATIENT IS A MINOR, GIVE PARENT'S OR GUARDIAN'S NAME

REASON FOR THIS VISIT

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

RESPONSIBLE PARTY INFORMATION

NAME: Last First Middle Initial **MARITAL STATUS**

RESIDENCE: Street City State Zip

MAILING ADDRESS Street City State Zip

HOW LONG AT THIS ADDRESS **HOME PHONE** **WORK PHONE**

PREVIOUS ADDRESS *(IF LESS THAN 3 YEARS)* Street City State Zip

SOCIAL SECURITY # **BIRTHDATE** Month Date Year

RELATIONSHIP TO PATIENT

EMPLOYER **OCCUPATION** **NO. YEAR EMPLOYED**

SPOUSE'S NAME: Last First Middle Initial

RELATIONSHIP TO PATIENT

EMPLOYER **OCCUPATION** **NO. YEAR EMPLOYED**

WORK PHONE # **BIRTHDATE** Month Date Year

EMERGENCY INFORMATION *(Information of a relative not living with you)*

NAME: Last First **PHONE #**

ADDRESS: Street City State Zip

DENTAL INSURANCE INFORMATION *(Primary Care)*

INSURED'S NAME

INSURANCE CO.

INSURANCE CO. ADDRESS

INSURED'S EMPLOYER

INSURED'S SOCIAL SECURITY #

GROUP # **LOCAL #**

2ND DENTAL INSURANCE INFORMATION *(if necessary)*

INSURED'S NAME

INSURANCE CO.

INSURANCE CO. ADDRESS

INSURED'S EMPLOYER

INSURED'S SOCIAL SECURITY #

GROUP # **LOCAL #**

JEFFREY S. THALLER, DMD

General Dentistry

It is important that i know about your Medical and Dental history. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY

HOW LONG SINCE YOU HAVE SEEN A DENTIST?

LAST COMPLETE DENTAL EXAM DATE

LAST FULL MOUTH X-RAYS DATE *(I6 SMALL FILMS OR PANORAMIC)*

ARE YOU HAVING PROBLEMS NOW? Yes No

What are they?

IS YOUR PRESENT DENTAL HEALTH POOR? Yes No

DO YOU SWEAR DENTURES? (PARTIALS OR FULL) Yes No

WOULD YOU LIKE TO KNOW MORE ABOUT PERMANENT REPLACEMENTS? Yes No

ARE YOU APPREHENSIVE ABOUT DENTAL TREATMENT? Yes No

HAVE YOU HAD ANY PERIODONTAL (GUM) TREATMENTS? Yes No

DO YOUR GUMS BLEED, FEEL TENDER, OR IRRITATED? Yes No

ARE YOUR TEETH SENSITIVE TO HOT, COLD, SWEETS, OR PRESSURE? (CIRCLE) Yes No

ARE YOU UNHAPPY WITH THE APPEARANCE OF YOUR TEETH? Yes No

ARE YOU AWARE OF GRINDING OR CLENCHING YOUR TEETH? Yes No

DO YOU HAVE HEADACHES, EARACHES, OR NECK PAINS? Yes No

HAVE YOU WORN BRACES ON YOUR TEETH? (ORTHODONTICS) Yes No

DO YOU HAVE DISCOLORED TEETH THAT BOTHER YOU? Yes No

WOULD YOU LIKE YOUR SMILE TO LOOK BETTER OR FEEL DIFFERENT? Yes No

DO YOU REGULARLY USE DENTAL FLOSS? Yes No

NAME OF PREVIOUS DENTIST

CITY **STATE**

HOW DO YOU FEEL ABOUT YOUR TEETH?

PLEASE RANK THE FOLLOWING IN ORDER IN WHICH THEY WOULD KEEP YOU FROM HAVING DENTAL TREATMENT

Fear of pain

Cost of treatment

Lack of concern

Missing work time

MEDICAL HISTORY

DO YOU HAVE ANY CURRENT HEALTH PROBLEMS? Yes No

ARE YOU UNDER A PHYSICIAN'S CARE NOW? Yes No

For what?

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

ARE YOU PREGNANT? Yes No

DO YOU SMOKE? Yes No

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:

HEART DISEASE OR ATTACK	A.I.O.S / A.R.C.	BRUISE EASILY
ANGINA PECTORIS	HEPATITIS A (INFECTIONS)	EMPHYSEMA
HIGH BLOOD PRESSURE	HEPATITIS B (SERUM)	TUBERCULOSIS (TB)
HEART MURMUR	LIVER DISEASE	ASTHMA
RHEUMATIC FEVER	BLOOD TRANSFUSION	HAY FEVER
CONGENIAL HEART LESIONS	DRUG ADDICTION	SINUS TROUBLE
MITRAL VALVE PROLAPSE	HEMOPHILIA (BLEEDING PROBLEMS)	ALLERGIES OR HIVES
ARTIFICIAL HEART VALVE	FEVER BLISTERS	DIABETES
HEART PACEMAKER	EPILEPSY OR SEIZURES	THYROID DISEASE
HEART SURGERY	NERVOUSNESS	RADIATION TREATMENT
ARTIFICIAL JOINTS (HIP, KNEE)	PSYCHIATRIC TREATMENT	ARTHRITIS
ANEMIA	GLAUCOMA	CORTISONE MEDICINE
STROKE	CHEMOTHERAPY (CANCER, LEUKEMIA)	PAIN IN JAW JOINTS
KIDNEY TROUBLE	VENERIAL DISEASE (SYPHILLIS, GONORRHEA, ETC.)	ALCOHOLISM
ULCERS		COSMETIC SURGERY

ARE YOU ALLERGIC TO OR HAVE REACTIVE ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

ASPIRIN	LOCAL ANETHETIC	ERYTHROMYCIN
NITROUS OXIDE	CODEINE	PENICILLIN

ARE YOU AWARE OF BEING ALLERGIC TO ANY OTHER MEDICATIONS OR SUBSTANCES? Yes No

If yes, please list:

IS THERE ANY OTHER MEDICAL OR DENTAL INFORMATION THAT YOU FEEL I SHOULD KNOW ABOUT?

FAMILY PHYSICIAN

PHONE NUMBER

PATIENT SIGNATURE *(PARENT OF CHILD)*

DATE

DENTIST SIGNATURE