Antelope Dental Associates

Patient Registration and Health History

Patient Name _____
Address _____
City, State, Zip _____
Sex M / F Birth date: _____
Patient SS# _____
Single ____ Married ____ Widowed ____ Divorced ____
Spouse's Name _____

Employer _____
Work Address _____
Primary Insurance Co. _____
Group # _____
Secondary Insurance Co. _____
Group # _____
How did you hear about us? _____

Preferred Contact Method

Home Phone _____ ☐
Work Phone _____ ☐
Cell Phone _____ ☐
E-mail _____ ☐

In case of emergency, contact:
Name _____ Relationship _____
Phone _____

Medical History

Physician's Name: _____ Medical Insurance # _____ Date of last visit: _____

What is your estimate of your general health? Please circle: Excellent Good Fair Poor

Please mark 'Yes' or 'No' if you have had any of the following:

		Yes	No
1.	Hospitalization for illness or injury _____	☐	☐
2.	Allergic reactions (list below) _____	☐	☐
3.	Heart problems, or cardiac stent within the last 6 months ___	☐	☐
4.	History of infective endocarditis _____	☐	☐
5.	Artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6.	Pacemaker or implantable defibrillator _____	☐	☐
7.	Orthopedic implant (joint replacement) _____	☐	☐
8.	Rheumatic or scarlet fever _____	☐	☐
9.	High or low blood pressure _____	☐	☐
10.	A stroke (taking blood thinners) _____	☐	☐
11.	Anemia or other blood disorder _____	☐	☐
12.	Prolonged bleeding due to a slight cut (INR >3.5) _____	☐	☐
13.	Emphysema, shortness of breath, sarcoidosis _____	☐	☐
14.	Tuberculosis, measles, chicken pox _____	☐	☐
15.	Asthma _____	☐	☐
16.	Breathing or sleep problems (i.e. sleep apnea, snoring, sinus) __	☐	☐
17.	Kidney disease _____	☐	☐
18.	Liver disease _____	☐	☐
19.	Jaundice _____	☐	☐
20.	Thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21.	Hormone deficiency _____	☐	☐
22.	High cholesterol or taking statin drugs _____	☐	☐
23.	Diabetes (HbA1c = _____) _____	☐	☐
24.	Stomach or duodenal ulcer _____	☐	☐
25.	Digestive disorders (i.e. celiac disease, gastric reflux) _____	☐	☐
26.	Osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	☐	☐
27.	Arthritis _____	☐	☐
28.	Autoimmune disease _____ (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29.	Glaucoma _____	☐	☐
30.	Contact lenses _____	☐	☐
31.	Head or neck injuries _____	☐	☐
32.	Epilepsy, convulsions (seizures) _____	☐	☐
33.	Neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
34.	Viral infections and cold sores _____	☐	☐
35.	Any lumps or swelling in the mouth _____	☐	☐
36.	Hives, skin rash, hay fever _____	☐	☐
37.	STI/STD/HPV _____	☐	☐
38.	Hepatitis (Type ____) _____	☐	☐
39.	HIV/AIDS _____	☐	☐
40.	Tumor, abnormal growth _____	☐	☐
41.	Radiation therapy _____	☐	☐
42.	Chemotherapy, immunosuppressive medication _____	☐	☐
43.	Emotional difficulties _____	☐	☐
44.	Psychiatric treatment _____	☐	☐
45.	Antidepressant medication _____	☐	☐
46.	Alcohol/recreational drug use _____	☐	☐
Are you:			
47.	Presently being treated for any other illness _____	☐	☐
48.	Aware of a change in your health in the last 24 hours ____ (i.e. fever, chills, new cough, or diarrhea)	☐	☐
49.	Taking medication for weight management _____	☐	☐
50.	Taking dietary supplements _____	☐	☐
51.	Often exhausted or fatigued _____	☐	☐
52.	Experiencing frequent headaches _____	☐	☐
53.	A smoker, smoked previously or use smokeless tobacco __	☐	☐
54.	Considered a touchy/sensitive person _____	☐	☐
55.	Often unhappy or depressed _____	☐	☐
56.	Taking birth control pills _____	☐	☐
57.	Currently pregnant _____	☐	☐
58.	Having prostate disorders _____	☐	☐

Please list allergies (including latex): ☐ None

_____ _____
_____ _____
_____ _____

List current medications (including birth control): ☐ None

_____ _____
_____ _____
_____ _____

Over

ASA _____ (1-6)

Dental History

Previous Dentist _____ How long were you a patient there? _____

When was your last visit? _____

How often do you see your dentist? ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

How would you rate your dental health? Excellent Good Fair Poor

Main reason for coming in today: _____

Personal History

		Yes	No
1.	Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [_____] _____	☐	☐
2.	Have you had an unfavorable dental experience? _____	☐	☐
3.	Have you ever had complications from past dental treatment? _____	☐	☐
4.	Have you ever had trouble getting numb or had any reactions to local anesthetic? _____	☐	☐
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted? _____	☐	☐
6.	Have you had any teeth removed or missing teeth that never developed? _____	☐	☐

Gum and Bone

7.	Do your gums bleed or are they painful when brushing or flossing? _____	☐	☐
8.	Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	☐	☐
9.	Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
10.	Is there anyone with a history of periodontal disease in your family? _____	☐	☐
11.	Have you experienced gum recession? _____	☐	☐
12.	Have you ever had any teeth become loose on their own (without any injury), or do you have difficulty eating an apple? ____	☐	☐
13.	Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____	☐	☐

Tooth Structure

14.	Have you had any cavities within the past 3 years? _____	☐	☐
15.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____	☐	☐
16.	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	☐	☐
17.	Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____	☐	☐
18.	Do you have grooves or notches on your teeth near the gumline? _____	☐	☐
19.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	☐	☐
20.	Do you frequently get food caught between any teeth? _____	☐	☐

Bite and Jaw Joint

21.	Do you have problems with your jaw joint (pain, sounds, limited opening, locking, popping)? _____	☐	☐
22.	Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____	☐	☐
23.	Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____	☐	☐
24.	Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____	☐	☐
25.	Are your teeth becoming more crooked, crowded, or overlapped? _____	☐	☐
26.	Are your teeth developing spaces or becoming loose? _____	☐	☐
27.	Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? _____	☐	☐
28.	Do you place your tongue between your teeth or close your teeth against your tongue? _____	☐	☐
29.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	☐	☐
30.	Do you clench your teeth in the daytime or make them sore? _____	☐	☐
31.	Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? _____	☐	☐
32.	Do you wear or have you ever worn a bite appliance? _____	☐	☐

Smile Characteristics

33.	Is there anything about the appearance of your teeth that you would like to change? _____	☐	☐
34.	Have you ever whitened (bleached) your teeth? _____	☐	☐
35.	Have you felt uncomfortable or self conscious about the appearance of your teeth? _____	☐	☐
36.	Have you been disappointed with the appearance of previous dental work? _____	☐	☐

I certify to the best of my knowledge that I have answered every question completely and accurately. I will inform the dentist of any change in my health and/or medication. I consent to allow information in my dental chart to be transferred electronically or by mail for dental and/or insurance purposes or to inform myself of dental information, such as recall appointments, changes in office policies, etc. I also assign directly to William J. Black, DDS, Inc. dba Antelope Dental Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient or Guardian Signature X _____ **Date:** _____

Doctor Notes: _____

_____

_____

Signed: _____ Date: _____