Bosque Valley Family Dental

PATIENT REGISTRATION AND HEALTH HISTORY

Patient Information

Patient Name: _____ Date:_____
Last First MI

□ Male □ Female □ Married □ Single □ Child □ Other:_____

Social Security #: _____TXDL#_____ Birth Date:_____

Mailing Address:_____
Street Apartment #

_____
City State Zip Code

Phone (Home): _____ (Work): _____ Ext:_____ (Cell): _____

Guarantor/Spouse Information

The following is for: □ the person responsible for payment □ the patient's spouse

Name: _____

□ Male □ Female □ Married □ Single □ Child □ Other _____

Social Security #: _____TXDL#_____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ (Cell): _____

Physical Address _____
Street Apartment #

_____
City State Zip Code

Employer:_____ Address:_____

Primary Dental Insurance Information

Name of Subscriber: _____ Is Subscriber a patient? □ Yes □ No
Last First MI

Subscriber's Birth Date: _____ ID/SS #_____ Group #:_____

Subscriber's Home Address: _____
Street City State Zip Code

Subscriber's Employer: _____ Phone:_____

Address: _____
Street City State Zip Code

Patient's relationship to subscriber: □ Self □ Spouse □ Child □ Other_____

Insurance Company: _____

Address and Phone:_____
Street City State Zip Code Phone

Dental History

Date of last dental visit:_____

Are you happy with the appearance of your teeth? □ Yes □ No

Does dental treatment make you nervous? □ Yes □ No If Yes, □ Slightly □ Moderately □ Extremely

Have you ever had a bad dental experience? □ Yes □ No

Previous periodontal treatment? □ Yes □ No

Have you ever had any complications following dental treatment? □ Yes □ No

If yes, please explain:_____

Referred by:_____□ Patient □ Doctor □ PhoneBook □ Friend □ Other_____

Health Information

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV	☐ Cortisone Medicine	☐ Hepatitis	☐ Radiation/Chemotherapy
☐ Allergies (Seasonal)	☐ Diabetes	☐ High Blood Pressure	☐ Respiratory Problems
☐ Anemia	☐ Drug/Alcohol Addiction	☐ Jaundice	☐ Rheumatic Fever
☐ Angina	☐ Emphysema	☐ Kidney Disease	☐ Sickle Cell Disease
☐ Artificial Joints	☐ Epilepsy	☐ Liver Disease	☐ Sinus Problems
☐ Arthritis	☐ Excessive Bleeding	☐ Mental Disorders	☐ Stomach Problems/Ulcers
☐ Asthma	☐ Fainting/Dizziness	☐ Nervous Disorders	☐ Stroke
☐ Blood Disease	☐ Glaucoma	☐ Pacemaker	☐ Thyroid Disease
☐ Bruise Easily	☐ Growths or Tumors	☐ Pain in Jaw Joints	☐ **Pregnancy**
☐ Cancer	☐ Head Injuries	☐ Tuberculosis	**Due Date** _____
☐ Heart Disease	☐ Venereal Disease_____	☐ Psychiatric Treatment	Nursing?_____
☐ Cold Sores/Fever Blisters/Ulcers	☐ Heart Murmur/Heart Valve	☐ Other: _____	☐ Birth Control
☐ Cosmetic Surgery	☐ Heart Surgery	_____	

Specifics on items checked above:_____

☐ Have taken or currently take Actonel, Boniva, Didronel, Fosamax, or Skelid.

☐ Have taken or now take prescription diet drugs, including Phen Fen or Redux.

Name of Physician:_____Phone:_____

Current medications (including OTC, vitamins, herbal):_____

_____

Are you **allergic** to or had any adverse reaction to any medication or substance? ☐ Yes ☐ No Please List_____

_____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

Are you now under the care of a physician? ☐ Yes ☐ No If yes, please explain:_____

Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain:_____

Do you smoke or use tobacco products? ☐ Yes ☐ No If yes, how much?_____

Do you have more than 7 alcoholic drinks (including beer and wine) in a week? ☐ Yes ☐ No

Do you have pain in your chest, shortness of breath, or get very tired when you walk up stairs or take a walk? ☐ Yes ☐ No

Do you ever wake up from sleep short of breath? ☐ Yes ☐ No Do you use more than 2 pillows to sleep? ☐ Yes ☐ No

Do your ankles swell during the day? ☐ Yes ☐ No

Have you gained or lost more than 10 lbs. during the past year? ☐ Yes ☐ No Are you on a special diet? ☐ Yes ☐ No

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date:_____ _____

Dr's Notes