**Patient Registration and Dental/Medical History Form**

**Patient Information**

PRINT FULL NAME (First, Full Middle Name, Last Name) DATE OF BIRTH

STREET ADDRESS

CITY STATE ZIP

SOCIAL SECURITY NUMBER DRIVER’S LICENSE NUMBER / ISSUING STATE PHONE NUMBER

OTHER OR FORMER NAMES (aka, maiden names, married names, surnames, etc.) EMAIL ADDRESS

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of Employment Occupation

**Emergency Contact Information**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance Information**

Subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance Information**

Subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about us?**

Internet \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental History**

Purpose of this appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Problems/Concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last dental visit/cleaning: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you happy with your smile?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently have any dental pain? \_\_\_Yes \_\_\_No Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had unhappy dental experiences? \_\_\_Yes \_\_\_No Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any injuries to your mouth/teeth/head? \_\_\_Yes \_\_\_No Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you mouth-breath/snore? \_\_\_Yes \_\_\_No Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any jaw issues (clicking/popping/pain)? \_\_\_Yes \_\_\_No Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear orthodontic (braces) appliances? In the past? \_\_\_Yes \_\_\_No Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental Hygiene Routine**

How many times per day do you brush? \_\_\_\_\_\_\_\_\_\_\_\_

Do you use fluoridated toothpaste? \_\_\_\_Yes \_\_\_\_No Do you use a manual or an electric toothbrush? \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you floss? \_\_\_\_Yes \_\_\_\_No

How many times per week do you floss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use mouth rinse? \_\_\_\_Yes \_\_\_\_No Type:\_\_\_\_\_\_\_\_\_\_

**Medical History**

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Medical Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_State: \_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under a doctor’s care for a specific reason? \_\_Yes \_\_No Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any medications? \_\_\_Yes \_\_\_No Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any emotional/mental conditions we should be aware of? \_\_\_Yes \_\_\_No Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any physical conditions we should be aware of? \_\_\_Yes \_\_\_No Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any medical conditions we should be aware of? \_\_\_Yes \_\_\_No Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any medications? \_\_\_Yes \_\_\_No Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any other allergies (food/animals/latex/local anesthetics, etc.)? \_\_\_Yes \_\_\_No Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized? \_\_\_Yes \_\_\_No Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any surgeries? \_\_\_Yes \_\_\_No Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you require pre-medication before dental treatment? \_\_\_Yes \_\_\_No Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had or experienced any of the following? **(Check all that apply)**

\_\_AIDS/HIV \_\_Anemia \_\_Arthritis \_\_Asthma \_\_Autism

\_\_Bladder Infection \_\_Bleeding disorder

\_\_Blood Transfusions

\_\_Blurred Vision \_\_Cancer/Tumors

\_\_Excessive Thirst

\_\_Dry Mouth.

\_\_Frequent Urination

\_\_Difficulty Urinating

\_\_Cerebral Palsy

\_\_Chemotherapy

\_\_Radiation Treatment \_\_Sinus Problems

\_\_Chest Pain (angina)

\_\_Persistent Cough

\_\_Bleeding Problems

\_\_Frequent Headaches

\_\_Diabetes

\_\_Diarrhea

\_\_Eye disease(s) \_\_Eating Disorder \_\_Epilepsy

\_\_Earaches/Ringing

\_\_Fainting/Dizziness

\_\_Seizures

\_\_Vomiting/Nausea

\_\_ADD/ADHD

\_\_Joint Replacement

\_\_Headaches

\_\_Hearing Loss \_\_Heart Murmurs \_\_Heart Disease

\_\_Heart Attack

\_\_Heart Defects

\_\_High Blood Pressure \_\_Hemophilia \_\_Hepatitis A/B/C

\_\_Herpes

\_\_Kidney Infection \_\_Liver Infection

\_\_Mouth Sores/Ulcers

\_\_Organ Transplant

\_\_Pacemaker

\_\_Prosthetic Heart

Valve

\_\_Psychiatric Care \_\_Rheumatic Fever \_\_Thyroid Problems

\_\_Shortness of Breath

\_\_Swollen Ankles

\_\_Difficulty

Swallowing

\_\_Stroke/Hardening of

Arteries

\_\_Sexual Transmitted

Disease(s)

\_\_Stomach

Problems/Ulcers

\_\_Tobacco in any form

\_\_Alcohol

\_\_Contact Lenses

**WOMEN ONLY:** Are you or could you be pregnant? \_\_\_Yes \_\_\_No Taking Birth Control Pills? \_\_\_Yes \_\_\_No

**ALL PATIENTS:**

Do you have any other medical information that we need to be aware of that has not yet been covered in this form? \_\_\_Yes \_\_\_No Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appointment Policy**

Your scheduled appointments are reserved specifically for you. Any late arrivals or missed appointments affect many patients,

including your own appointment. It may be several weeks before we are able to reschedule the appointment. We have listed our “Appointment Policies” below:

• If a cancellation is unavoidable, please call our office at least **24 hours in advance** at (214)823-2182 so that we may give your

appointment time to another patient. If a cancellation is made with less than 24 hours’ notice, this may be considered a

missed/broken appointment.

•We require a **VERBAL CONFIRMATION** in order to hold your reserved appointment. Failure to do so may result in forfeiting your appointment time to a patient who is on our appointment waiting list.

• If you fail to arrive for your scheduled appointment without notice, this may be considered a missed/broken appointment.

• Please arrive at least 5 minutes early for your appointment. If you arrive more than 15 minutes late for your appointment, it

may need to be canceled due to scheduling restrictions. This appointment may be considered a missed/broken appointment.

• A missed/broken appointment may result in a $50.00 charge for failure to cancel/reschedule the appointment in a timely

manner. It is the discretion of HF Dental whether or not this charge will be applied.

• **Three missed/broken appointments** may result in the termination of our dentist-patient relationship.

I understand that the information given is correct to the best of my knowledge and will be held in the strictest of confidence. I understand that it is my responsibility to inform Cooper Family Dental of any changes in my medical status, insurance and/or contact information. I also understand Cooper Family Dental’s late/canceled/failed appointment policy.

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_