GROUT FAMILY DENTISTRY, PC
A family tradition of beautiful, healthy smiles

Patient #.______________________

Health History and Registration

Name______________________________Birthdate________________Age______Today's Date______________

Home Address____City______________________State__________Zip______

Please Circle One: Single Married Divorced Widowed Home Phone______________________

Name of Spouse (Parent if Minor)____________________________Person Responsible for Account__________________________

Address (if different from above)______________________Your Employer________________________Your Soc. Sec. #__________

Work Phone______________Spouse's Employer______________________Spouse's Soc. Sec.#________________Work Phone____

Primary Dental Insurance Co.____________________________Subscriber's Name__________________________Address________

__________Phone Number________________Relationship______________Group#________Secondary Dental Insurance Co.__________

Referred to us by (important)____________________________Reason for this visit____________________________________

Name & Address of a relative__________________________Who should be notified in case of an emergency?______________________

or friend not living with you ____________________________Relationship____________________Phone Number________________

It is important that we 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

• Medical History •			• Dental History •	
YES	Do you have CURRENT HEALTH PROBLEMS?	NO		How LONG SINCE you have seen a Dentist?	
YES	Are you under a PHYSICIAN'S CARE within the last 5 years?	NO		Last COMPLETE Dental Exam?	
	For what?			Last FULL MOUTH X-RAYS, DATE?	
	Have you had any of the following:			(machine that rotates around your entire head, or 16 small film)	
YES	Rheumatic Fever, Heart murmur or heart valve problem?	NO	YES	Are you having PROBLEMS now?	NO
YES	Any type of Heart Problem, Angina, Chest Pain or Surgery?	NO		What?	
YES	High Blood Pressure, Low Blood Pressure or Stroke?	NO	YES	Has your dental care been IRREGULAR in the last 5 years?	NO
YES	Diabetes? Any Maternal, Paternal Diabetes?	NO	YES	Is your present dental health POOR?	NO
YES	Fainting Spells, Seizures, or Epilepsy?	NO	YES	Do you think you will lose all of your teeth soon?	NO
YES	Ulcers or Stomach problems?	NO	YES	Do you expect to wear dentures some day?	NO
YES	Nervous Problems?	NO	YES	Have you had a BAD dental experience in the past?	NO
YES	Asthma or any Respiratory Problems?	NO	YES	Are you APPREHENSIVE about dental treatment?	NO
YES	Hepatitis, or any Liver Damage?	NO	YES	Have you been given a local anesthetic?	NO
YES	Abnormal Bleeding, Anemia, Leukemia, or Blood Transfusion?	NO	YES	Are you dissatisfied with any PAST dental treatment?	NO
YES	Surgery or Radiation for any Growths or Tumors?	NO	YES	Have you had any PERIODONTAL (GUM) treatments?	NO
YES	Are you taking ANY MEDICATIONS now?	NO	YES	Are you troubled by BAD BREATH?	NO
	Name them:		YES	Does food usually wedge between certain teeth?	NO
YES	Are you Allergic to Penicillin or any other Antibiotics?	NO		Where?	
YES	Are you Allergic to Codeine, Aspirin, or other pain medication?	NO	YES	Do your gums BLEED, or feel TENDER or IRRITATED?	NO
YES	Any Drug Allergies to or Local Anesthetics?	NO	YES	Are your teeth sensitive to HOT, COLD, SWEETS, PRESSURE? (circle)	NO
YES	Kidney or Bladder Problems? Swollen Ankles?	NO	YES	Are you UNHAPPY with the APPEARANCE of your teeth?	NO
YES	Arthritis?	NO	YES	Are you aware of GRINDING or CLENCHING your teeth?	NO
YES	Prosthetic Replacement-Hip, Knee, Heart Valve, Other?	NO	YES	Are your jaws or teeth SORE when you awake from sleep?	NO
YES	Psychiatric Care, Stress Therapy or Counseling?	NO	YES	Do you have HEADACHES, EARACHES or NECK PAINS?	NO
YES	Have you ever been exposed or tested HIV Positive (AIDS)	NO	YES	Have you LOST teeth, other than wisdom?	NO
YES	Have you had a venereal disease?	NO	YES	Have the lost teeth been REPLACED?	NO
YES	Measles? Mumps?	NO	YES	Has REPLACEMENT been RECOMMENDED to you?	NO
YES	Taken hallucinogenic drugs, LSD, etc.?	NO	YES	Do you have LOOSE, TIPPED or SHIFTING teeth? (circle)	NO
YES	(Women) Are you pregnant? Date Due:	NO	YES	Have you worn BRACES on your teeth? (ORTHODONTICS)	NO
	Date of test physical examination	NO	YES	Have you had NERVES or any teeth REMOVED?	NO
	FAMILY PHYSICIAN: PHONE:		YES	Have any teeth DARKENED from nerve removal/Endodontics?	NO
	Other Medical or Dental Information you feel I should know about:		YES	Have any teeth DISCOLORED from old fillings?	NO
			YES	Does this discoloration bother you?	NO
	PATIENT SIGNATURE: Date:		YES	Do you have problems with teeth/fillings BREAKING?	NO
	(Parent if Minor)		YES	Do you REGULARLY use DENTAL FLOSS?	NO
	DENTIST SIGNATURE: Date:		YES	Do you have Head/Jaw pain or an injury?	NO

Name of Previous Dentist:__________________________________City__________________________State________

How do you feel about your teeth____

Please rank the following in the order in which they would keep you from having dental treatment:

FEAR of pain:____________COST of treatment______________LACK of concern__________MISSING WORK TIME__________