R. KEITH THETFORD, D.D.S.

PATIENT REGISTRATION AND HEALTH HISTORY

PERSONAL INFORMATION

Date: ____________________

Name: ____________________

Address: ____________________ Home Phone: ____________________

City: ____________________ State: ____________________ Zip: ____________________

Occupation: ____________________

Business Address: ____________________ Business Phone: ____________________

City: ____________________ State: ____________________ Zip: ____________________

Bithdate: ____________________ Age: ________ Married ______ Single ______ Divorced ______ Widow ______

Social Security Number: ____________________ Driver's License Number: ____________________

Spouse's Name: ____________________ Occupation: ____________________

Spouse's Business Address: ____________________ Business Phone: ____________________

Spouse's Social Security Number: ____________________

Person financially responsible for account: ____________________

Person to contact in case of emergency: ____________________

E-MAIL ADDRESS: ____________________

INSURANCE INFORMATION

YOUR COVERAGE
IS THE
PRIMARY CARRIER

Insurance Company ____________________

Employee ____________________

Employed By ____________________

Group Number ____________________

Union or Local Number ____________________

DENTAL INFORMATION

Has any member of your family been treated in our office previously? ____________________

Whom may we thank for referring you to our office? ____________________

What attracted you to our office? ____________________

What do you feel you need dentally? ____________________

Evaluate your oral health. Excellent ______ Good ______ Fair ______ Poor ______

On a scale of 1-10 (10 being highest) what priority do you give your teeth? 1 2 3 4 5 6 7 8 9 10

(OVER)

HEALTH HISTORY

CIRCLE

1. Are you having pain or discomfort at this time? .... YES NO
2. Do you feel very nervous about having dental treatment? .... YES NO
3. Have you ever had a bad experience in the dental office? .... YES NO
4. Have you been a patient in the hospital during the past two years? .... YES NO
5. Have you been under the care of a medical doctor during the past two years? .... YES NO

   Physician's Name ____________________

   Address ____________________ Phone # __________

6. Have you taken any medicine or drugs during the past two years? .... YES NO

   Are you now taking any medication, drugs or pills? .... YES NO

   If yes, please list: ____________________

7. Are you allergic or have you reacted adversely to any of the following medications? .... YES NO

Aspirin	Nitrous Oxide	Valium	Local Anesthetic
Darvon	Erythromycin	Scopolamine	(Novocain or Xylocaine)
Codeine	Tetracycline	Penicillin	Sleeping Pills
Demerol	Percodan	Other Antibiotics	(Nembutal/Seconal)

8. Are you aware of being allergic to any other medications or substance? .... YES NO

   If yes, please list: ____________________

9. Circle any of the following which you have had or have at present:

Heart Failure	Emphysema	A.I.D.S.
Heart Disease or Attack	Cough	Hepatitis A (infectious)
Angina Pectoris	Tuberculosis (TB)	Hepatitis B (serum)
High Blood Pressure	Asthma	Liver Disease
Heart Murmur	Hay Fever	Yellow Jaundice
Rheumatic Fever	Sinus Trouble	Blood Transfussion
Congenital Heart Lesions	Allergies or Hives	Drug Addiction
Scarlet Fever	Diabetes	Hemophilia
Artificial Heart Valve	Thyroid Disease	Venereal Disease (Syphilis, Gonorrhea)
Heart Pacemaker	X-ray or Cobalt Treatment	Cold Sores
Heart Surgery	Chemotherapy (Cancer, Leukemia)	Fever Blisters
Artificial Joints (Hip, Knee)	Arthritis	Epilepsy or Seizures
Anemia	Rheumatism	Fainting or Dizzy Spells
Stroke	Cortisone Medicine	Nervousness
Kidney Trouble	Glaucoma	Psychiatric Treatment
Ulcers	Pain in Jaw Joints	Sickle Cell Disease
Cosmetic Surgery		Bruise Easily

10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? .... YES NO
11. Do your ankles swell during the day? .... YES NO
12. Do you use more than 2 pillows to sleep? .... YES NO
13. Have you lost or gained more than 10 pounds in the past year? .... YES NO
14. Do you ever wake up from sleep short of breath? .... YES NO
15. Are you on a special diet? .... YES NO
16. Has your medical doctor ever said you have a cancer or tumor? .... YES NO
17. Do you have any disease, condition, or problem not listed? .... YES NO

FOR WOMEN ONLY:

Are you pregnant? ☐ Yes ☐ No If yes, what month? __________ . Are you taking birth control pills? ☐ Yes ☐ No

ABOVE INFORMATION IS TRUE

Patient Signature ____________________ Date ____/____/____

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient ____________________ Date __________ Witness ____________________

Parent or Responsible Party ____________________ Relationship to Patient ____________________