Health History & Registration

Patient's Name: Last _____ First_____ M.I.____

Sex: ( ) M ( )F Birth date:_____ Age_____ Social Sec #:_____ Today's Date: _____

( )Single ( )Married ( )Child If Patient is a Minor, Parent's or Guardian's name: _____

Home Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (____)_____ Work: (____)_____ext._____ Cell: (___)_____

Person Responsible for Account

( ) Same as Above

Name: Last _____First_____ Birth date: _____

Driver License #: _____ Social Sec #: _____ Relation: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____)_____ Work: (____)_____Cell: (____)_____

Employer: _____ Occupation: _____ How long there? _____

Dental Insurance Information

Primary Insurance

Insurance Co. Name: _____ Phone: _____ Grp/Policy #: _____
Insured's Name: _____ Insured's Birth date: _____ Relation: _____
Insured's Social Sec. #: _____ Insured's Employer: _____

Secondary Insurance

Insurance Co. Name: _____ Phone: _____ Grp/Policy #: _____
Insured's Name: _____ Insured's Birth date: _____ Relation: _____
Insured's Social Sec. #: _____ Insured's Employer: _____

What is the reason for today's visit? _____
How long has it been since you last saw a dentist? _____
What did you have done at that time? _____
Have you been told that you have TMJ or grind your teeth? _____
Date of last dental X-rays? _____
Do you wear dentures? _____
Are your teeth or gums uncomfortable or sensitive? _____

Authorization

I authorize and give consent to my dental provider to perform agreed upon procedures that may be necessary for proper dental care. These include but are not limited to, diagnostic and therapeutic procedures, local anesthesia and the use of other medications as indicated. I confirm that the information on this page and the medical history are correct to the best of my knowledge.

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of the dental treatment.

Payment for all treatment and services rendered are my responsibility.

Patient Signature: _____ Date: _____

If patient is a child or requires a guardian

Parent/Guardian's Signature: _____ Date: _____

Ned S. Greenberg D.D.S., P.A.

Name of Physician: _____ Phone: (____)_____

Do you have or have ever had any of the following? Please check those that apply:

( ) Allergies/Hay Fever
( ) Anemia
( ) Arthritis
( ) Artificial Joints* (Rods, Fusions, Pins)
( ) Artificial Heart Valve*
( ) Asthma
( ) Bleeding disorders
( ) Breathing Problems
( ) Cancer
( ) Chemical Dependency
( ) Chemotherapy
( ) Diabetes
( ) Endocarditis*
( ) Epilepsy or Seizures
( ) Fainting or Dizziness
( ) Fever Blisters/Cold Sores
( ) Glaucoma
( ) Heart Disorder (Congenital)*
( ) Heart Infection*
( ) Heart Murmur*
( ) Heart Pace Maker*
( ) Heart Surgery*
( ) Hepatitis
( ) High Blood Pressure
( ) HIV*/AIDS
( ) Kidney Problems
( ) Liver Problems
( ) Mental Disorders
( ) Mitral Valve Prolapse*
( ) Osteoporosis (Bisphosphonates or any other Osteoporosis medication)
( ) Radiation Therapy
( ) Respiratory Problems
( ) Rheumatic Fever
( ) Rheumatism
( ) STD
( ) Sickle Cell Disease
( ) Sinus Problems
( ) Smoking/Vaping/Chewing Tobacco
( ) Stroke
( ) Surgical Shunt*
( ) Thyroid Problems
( ) Tuberculosis
( ) Ulcers
( ) Yellow Jaundice
( ) Other Conditions Not Listed

This condition may require antibiotic premedication for certain dental procedures.

Yes **No**

( ) ( ) Do you have any health problems that were not listed above or need further clarifications? If yes, explain: _____

( ) ( ) Are you now under the care of a physician? If yes, explain: _____
_____

( ) ( ) Are you taking any medications or herbals (prescriptions or over the counter, i.e., aspirin)? Please list all medications _____
_____
_____

( ) ( ) Are you allergic to any medications or substances? If yes, please check box below:
( ) Aspirin ( ) Penicillin ( ) Codeine ( ) Iodine ( ) Latex ( ) Other

Women (Please check): ( ) Pregnant ( ) Trying ( ) Nursing ( ) Taking oral contraceptives

Patient Signature:_____ Date:_____

Doctor Signature:_____Date:_____

Medical History Update

Date	Comments	Dr. Initials