



REGISTRATION AND HEALTH HISTORY

Circle: Male/Female

Name (PLEASE PRINT) Referred by

Date of Birth Age Circle: Single//Married/Widowed

Residential Address City State Zip Home Phone

Other Contact Information: Mobile Phone E-Mail address

Employed by City State Zip Business Phone

Present Position How long? Driver License Number

Name of Spouse

Emergency Contact Name and Phone Number Name of Parent or Guardian

TO OUR PATIENTS:

We do not bill insurance companies nor accept insurance. We will provide you with proof of dental services to submit to your private insurance carrier. When consenting to any treatment you would like to have done, a ClearChoice staff member will explain our different payment plan options. This office does not accept Medicare, Medicaid or any Federal Government sponsored or funded insurance plans. We ask that you pay or obtain approved financing of your treatment costs prior to beginning treatment.

DENTAL HISTORY

Name of General Dentist _____ Date of last visit: _____

What is your chief dental problem /complaint? _____

If you could improve your current dental condition, what would you like to be done? _____

Do you grind your teeth? Yes / No Have you ever been treated for periodontal gum disease? Yes / No

Do you have dry mouth? _____

Have you ever had surgery on your jaw? _____

Do you have any jaw joint implants? _____

Have you ever had a reaction to dental injections? _____

Are you under the care of a dentist for any dental problems? _____

Do you wear dentures? _____ If yes, do you enjoy wearing dentures? _____

Do you have any dental bridges or removable dental appliances? _____

Do you have any swelling or lumps in your mouth? _____

Have you ever worn or been told to wear a dental splint? _____

Are your teeth sensitive or painful? _____

Do you have pain in or near your ears? _____

Do you have unusual sounds in your ears or jaw when opening or closing your mouth? _____

MEDICAL HISTORY

It is important that we know about your dental and medical history. Many conditions may have a direct impact on your dental treatment. We will review this questionnaire and discuss it with you in detail. Information provided is strictly confidential and will not be released without your permission.

Are you in generally good health? Circle: Yes / No

Do you have any major medical problems? Yes / No If yes, please explain in detail.

Height _____ Weight _____

Are you under care of a physician now? _____ If yes, please explain in detail.

Name of current physician _____

Address of current physician _____

Have you ever had any problems with anesthesia? _____ If yes, please explain in detail.

Do you have a pacemaker / defibrillator? _____ Yes _____ No

Do you have the Implantable defibrillator card with you? _____ Yes _____ No Make/Model _____

Cardiologist Name: _____ Phone Number: _____

Have there been any changes in your health within the past 12 months? Circle: Yes / No Explain: _____

Have you ever been prescribed: Aredia, Zometa, Didronel, Actonel, Skelid, Fosamax, Boniva, Vioxx, Celebrex, prednisone, methotrexate (Rheumatrex, Trexall), or chemotherapeutic agents? _____

Have you ever had the above medications administered by IV? Circle: Yes / No

Have you ever been hospitalized, had any surgical procedures, or have had any serious illnesses within the past 5 years? Circle: Yes / No If yes, please explain in detail.

Have you ever made a complaint or had a bad outcome from any previous medical/dental care? If yes, please explain in detail.

Women only

Are you pregnant or is there any chance you may be pregnant?

Do you have problems associated with your menstrual period?

Are you nursing?

Circle

Yes / No

Yes / No

Yes / No

Are you taking birth control pills?

Yes / No

Do you have or have you had any of the following conditions?

	YES	NO		YES	NO
Allergies (Please List*)	_____	_____	Infective Endocarditis	_____	_____
Allergy to Any Medication	_____	_____	Jaundice	_____	_____
Anemia	_____	_____	Joint Disease	_____	_____
Anxiety	_____	_____	Kidney Disease	_____	_____
Any Immune Diseases	_____	_____	Latex Allergy	_____	_____
Arthritis	_____	_____	Liver Disease	_____	_____
Asthma	_____	_____	Low Blood Sugar	_____	_____
Breathing Problems	_____	_____	Lupus	_____	_____
Cancer	_____	_____	Neurological Problems	_____	_____
Chemotherapy	_____	_____	Organ Transplant	_____	_____
Chest Pain on Exertion	_____	_____	Osteoarthritis	_____	_____
Chronic Bronchitis	_____	_____	Osteoporosis	_____	_____
Chronic Fatigue	_____	_____	Painful or Replaced Joint(s)	_____	_____
Circulatory Problems	_____	_____	Panic Attacks	_____	_____
Congenital Heart Condition (Present from Birth)	_____	_____	Persistent Cough (which Produces Blood)	_____	_____
Damaged Heart	_____	_____	Psychiatric Care	_____	_____
Dental Splint	_____	_____	Radiation Treatment	_____	_____
Diabetes	_____	_____	Replaced Heart Valves	_____	_____
Drug Treatment	_____	_____	Rheumatic Fever	_____	_____
Emphysema	_____	_____	Rheumatoid Arthritis	_____	_____
Epilepsy / Seizures	_____	_____	Shortness of Breath	_____	_____
Excessive Bleeding	_____	_____	Sinus Problems	_____	_____
Fainting	_____	_____	Sleep Apnea / Snoring	_____	_____
Gall Bladder Problems	_____	_____	Stroke	_____	_____
Healing Problems	_____	_____	Teeth Grinding	_____	_____
Heart Attack	_____	_____	Thyroid Problems	_____	_____
Heart Murmur	_____	_____	Tobacco Use (Any Form)	_____	_____
Heart Problems (any other)	_____	_____	Tonsillitis	_____	_____
Hepatitis	_____	_____	Trauma to Head/Neck	_____	_____
Herpes	_____	_____	Tuberculosis	_____	_____
High or Low Blood Pressure	_____	_____	Ulcers / Gastric Reflux	_____	_____
History of Alcohol	_____	_____	Use of Alcohol	_____	_____
History of Tremors	_____	_____	Use of Drugs	_____	_____
History of Tumors	_____	_____	Valve Problems	_____	_____
HIV-AIDS	_____	_____	Vascular Graft	_____	_____
High Cholesterol	_____	_____	Venereal Disease	_____	_____
			Any Other Condition(s)	_____	_____
			Not Listed **	_____	_____

*Allergies: _____

**Other conditions not listed: _____

TREATMENT AUTHORIZATION AND ACKNOWLEDGEMENT

I acknowledge that I will discuss my accurate medical / dental history with my ClearChoice Dentist and have questions answered to my satisfaction. I consent to treatment as necessary or desirable for my care, diagnosis of dental disease, treatment, and dental emergencies. These procedures may include x-rays, molds, removal of existing dental prostheses, and an intraoral examination. In case of an emergency, I consent to treatment for that emergency. I understand that my doctor will discuss alternative forms of treatment to dental implants as well as their risks and benefits. My doctor will develop and present a specific treatment plans based upon his/her findings. I have the right to decline this recommended treatment plan based upon the evaluation to which I am consenting. I understand that I am responsible to visit a dentist for regular cleanings to maintain dental implants if I choose that form of treatment.

Patient or Patient Guardian

Date

IMPORTANT

- **Do not consume alcoholic beverages if taking “pain-killers.”**
- **Antibiotics will negate the effects of birth control pills.**
- **If you have any surgical procedures planned, you should arrange for transportation, as you may not be mentally or physically alert after the procedure.**
- **All medical and dental procedures involve a certain degree of risk. Death can occur, on rare occasions, with the use of all dental anesthetics.**
- **Consult your pharmacist regarding all side effects of prescribed medications.**
- **Advise your ClearChoice dentist of any changes in your medical/dental conditions during each office visit.**

Patient or Guardian Signature

Date

TO BE COMPLETED BY THE DOCTOR:

Comments on patient medical history: _____

Medical History Update:

Date	Comment	Patient Signature	Doctor's Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

