PATIENT REGISTRATION AND HEALTH HISTORY

Jeffrey H. Forrest, D.D.S., P.C.

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

1

DATE			
NAME			
PREFERRED NAME			
SPOUSE			
ADDRESS			
CITY		STATE	ZIP
HM. PH.		CELL PH.	
EMAIL			
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE			
NAME			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL			GRADE

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO.

2

DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE COMPANY
EMPLOYEE
DATE OF BIRTH
GROUP NO.
UNION OR LOCAL NO.
DATE EMPLOYED
EMP. SOCIAL SECURITY NO.

SECONDARY CARRIER

INSURANCE COMPANY
EMPLOYEE
DATE OF BIRTH
GROUP NO.
UNION OR LOCAL NO.
DATE EMPLOYED
EMP. SOCIAL SECURITY NO.

3

GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
THEIR NAME:		
REFERRED TO US BY		
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

4

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME	
DRIVERS LICENSE NO.	RELATIONSHIP TO PATIENT

YOU:

NAME	
OCCUPATION	
EMPLOYER	
BUSINESS ADDRESS	CITY
BUSINESS TELEPHONE	EXT.

YOUR SPOUSE:

NAME	
OCCUPATION	
EMPLOYER	
BUSINESS ADDRESS	CITY
BUSINESS TELEPHONE	EXT.

Jeffrey H. Forrest, D.D.S., P.C.

1 Are you having pain or discomfort at this time? ..... Yes No

2 Have you been under the care of a medical doctor during the past two years? ..... Yes No

Physician's Name _____

Address _____ Telephone _____

3 Have you taken any medication or drugs during the past two years? ..... Yes No

4 Are you now taking any medication, drugs or pills? ..... Yes No

If yes, please list _____

5 Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? ..... Yes No

If yes, please list _____

6 Indicate which of the following you have had or have at present. Cirlcle "Yes" or "No" to each item.

Heart Failure	Yes	No	Stroke	Yes	No	Hepatitis A(infectious)	Yes	No
Heart Disease or Attack	Yes	No	Artificial Joints(hip, knee, etc.)	Yes	No	Hepatitis B (serum)	Yes	No
Angina Pectoris	Yes	No	Kidney Trouble	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Ulcers	Yes	No	A.I.D.S	Yes	No
Heart Murmur	Yes	No	Diabetes	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Thyroid Problems	Yes	No	Cold Sores/Fever Blisters	Yes	No
Arteriosclerosis	Yes	No	Glaucoma	Yes	No	Blood Transfusion	Yes	No
Mitral Valve Prolapse	Yes	No	Cosmetic Surgery	Yes	No	Acid Reflux	Yes	No
Artificial Heart Valve	Yes	No	Emphysema	Yes	No	Anemia	Yes	No
Heart Pacemaker	Yes	No	Chronic Cough	Yes	No	Bruise Easily	Yes	No
Heart Surgery	Yes	No	Tuberculosis	Yes	No	Liver Disease	Yes	No
Rheumatism	Yes	No	Asthma	Yes	No	Epilepsy or Seizures	Yes	No
Pain in Jaw Joints	Yes	No	Seasonal Allergies	Yes	No	Fainting or Dizzy Spells	Yes	No
Cortisone Medicine	Yes	No	Sinus Trouble	Yes	No	Nervousness	Yes	No
Drug Addiction	Yes	No	Radiation Therapy	Yes	No	Psychiatric Treatment	Yes	No
			Chemotherapy	Yes	No	Tobacco Use	Yes	No
						E-Cig	Yes	No

7 When was your last dental appointment? .....

8 Do your gums bleed when you brush or floss? ..... Yes No

9 Have you noticed bad breath? ..... Yes No

10 Do you have a bad taste in your mouth? ..... Yes No

11 Sleep Apnea /Snoring ..... Yes No

12 Clinching/ Grinding ..... Yes No

13 Do you have or have had any disease, condition or problem not listed? ..... Yes No

14 If yes, please list _____

Are you currently taking blood thinners? ..... Yes No

15 Have you been informed that you need to be premedicated for dental treatment? ..... Yes No

For Women Only:

Are you pregnant? ..... Yes No

If yes, what month _____

Are you nursing? ..... Yes No

Are you taking birth control pills? ..... Yes No

I UNDERSTAND THE ABOVE INFORMATION IS NECESSARY TO PROVIDE ME WITH DENTAL CARE IN A SAFE AND EFFICIENT MANNER. I HAVE ANSWERED ALL QUESTIONS TRUTHFULLY AND TO THE BEST OF MY KNOWLEDGE.

* → **Patient Signature** _____ Date _____

CONSENT:

The undersigned herby authorize 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 authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with

(Name of Patient)_____

and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agent , embodies a certain risk. I understand the 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 further understand that a monthly service charge will be added to any account with no monthly payment 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 Signature** _____ Date _____ Witness _____

* → Patient or Responsible Party _____ Relationship to Patient _____