Henderson Family Dental
2011 N. Henderson Avenue
Dallas, TX 75206
214.823.2182

# Patient Registration and Dental/Medical History Form

## Patient Information

PRINT FULL NAME (First, Full Middle Name, Last Name)

STREET ADDRESS

CITY | STATE | ZIP

( )

SOCIAL SECURITY NUMBER | DATE OF BIRTH | PHONE NUMBER

DRIVER'S LICENSE NUMBER | ISSUING STATE

OTHER OR FORMER NAMES (aka, maiden names, married names, surnames, etc.) | EMAIL

PLACE OF EMPLOYMENT | OCCUPATION

## Emergency Contact Information

Full Name: _____Relationship: _____
Street Address: _____City: _____ State: ____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

## Primary Insurance Information

Subscriber: _____ Subscriber ID No.: _____ Group Number: _____
Insurance Company Name: _____ Phone Number: _____

## Secondary Insurance Information

Subscriber: _____ Subsiber ID No.: _____ Group Number: _____
Insurance Company Name: _____ Phone Number: _____

## How did you hear about us?

Internet _____ Patient Referral: _____
Other _____

## Dental History

Purpose of this appointment: _____ Problems/Concerns: _____
Date of Last visit: _____ Are you happy with your smile?_____
Do you currently have any dental pain? ___Yes ___No Explain:_____
Have you had unhappy dental experiences? ___Yes ___No Explain:_____
Have you had any injuries to your mouth/teeth/head? ___Yes ___No Explain:_____
Do you mouth-breath/snore? ___Yes ___No Explain:_____
Do you have any jaw issues (clicking/popping/pain)? ___Yes ___No Explain:_____
Do you wear orthodontic (braces) appliances? In the past? ___Yes ___No Explain:_____

## Dental Hygiene Routine

How many times per day do you brush? _____
Do you use fluoridated toothpaste? ____Yes ____No
Do you use a manual or an electric toothbrush? _____
Do you floss? ____Yes ____No
How many times per week do you floss? _____
Do you use mouth rinse? ____Yes ____No Type:_____

Physician's Name: _____ Date of Last Medical Visit: _____
Street Address: _____ City: _____State: ___ Zip: _____ Phone: _____
Are you currently under a doctor's care for a specific reason? __Yes __No Explain: _____
_____
Are you currently taking any medications? ___Yes ___No Explain: _____
_____
Do you have any emotional/mental conditions we should be aware of? ___Yes ___No Explain: _____
_____
Do you have any physical conditions we should be aware of? ___Yes ___No Explain: _____
_____
Do you have any medical conditions we should be aware of? ___Yes ___No Explain: _____
_____
Are you allergic to any medications? ___Yes ___No Explain: _____
Do you have any other allergies (food/animals/latex/local anesthetics, etc.)? ___Yes ___No Explain:_____
_____
Have you ever been hospitalized? ___Yes ___No Explain: _____
Have you had any surgeries? ___Yes ___No Explain: _____
Do you require pre-medication before dental treatment? ___Yes ___No Explain: _____

Have you ever had or experienced any of the following? (Check all that apply)

__AIDS/HIV
__Anemia
__Arthritis
__Asthma
__Autism
__Bladder Infection
__Bleeding disorder
__Blood Transfusions
__Blurred Vision
__Cancer/Tumors
__Excessive Thirst
__Dry Mouth.
__Frequent Urination
__Difficulty Urinating
__Cerebral Palsy
__Chemotherapy
__Radiation Treatment
__Sinus Problems
__Chest Pain (angina)
__Persistent Cough
__Bleeding Problems
__Frequent Headaches
__Diabetes
__Diarrhea
__Eye disease(s)
__Eating Disorder
__Epilepsy
__Earaches/Ringing
__Fainting/Dizziness
__Seizures
__Vomiting/Nausea
__ADD/ADHD
__Joint Replacement
__Headaches
__Hearing Loss
__Heart Murmurs
__Heart Disease
__Heart Attack
__Heart Defects
__High Blood Pressure
__Hemophilia
__Hepatitis A/B/C
__Herpes
__Kidney Infection
__Liver Infection
__Mouth Sores/Ulcers
__Lung Disease
__High Cholesterol
__Organ Transplant
__Pacemaker
__Prosthetic Heart Valve
__Psychiatric Care
__Rheumatic Fever
__Thyroid Problems
__Shortness of Breath
__Swollen Ankles
__Difficulty Swallowing
__Stroke/Hardening of Arteries
__Sexual Transmitted Disease(s)
__Stomach Problems/Ulcers
__Tobacco in any form
__Alcohol
__Contact Lenses

**WOMEN ONLY:**
Are you or could you be pregnant? ___Yes ___No Taking Birth Control Pills? ___Yes ___No

**ALL PATIENTS:**
Do you have any other medical information that we need to be aware of that has not yet been covered in this form? ___Yes ___No
Explain: _____
_____

## Appointment Policy

Your scheduled appointments are reserved specifically for you. Any late arrivals or missed appointments affect many patients, including your own appointment. It may be several weeks before we are able to reschedule the appointment. We have listed our "Appointment Policies" below:

- If a cancellation is unavoidable, please call our office at least **24 hours in advance** at (214)823-2182 so that we may give your

appointment time to another patient. If a cancellation is made with less than 24 hours' notice, this may be considered a missed/failed appointment.

- If you fail to arrive for your scheduled appointment without notice, this may be considered a missed/failed appointment.
- Please arrive at least 5 minutes early for your appointment. If you arrive more than 15 minutes late for your appointment, it may need to be canceled due to scheduling restrictions. This appointment may be considered a missed/failed appointment.
- **Three missed/failed appointments** may result in the termination of our dentist-patient relationship.

I understand that the information given is correct to the best of my knowledge and will be held in the strictest of confidence. I understand that it is my responsibility to inform Henderson Family Dental of any changes in my medical status, insurance and/or contact information. I also understand Henderson Family Dental's late/canceled/failed appointment policy.

Printed Name: _____

Signature: _____

Date: _____