Julian R. Chapman, DDS **561-272-0040**

FAX 561-272-0294

Health History & Registration

PATIENT INFORMATION

NAME Last _____ **First** _____ **Initial** _____ **Sex:** M F **Age** _____

Birthdate _____ **Soc. Sec. #** _____ **Today's Date** _____

If patient is a minor, give Parent's or Guardian's Name _____

Who may we thank for referring you to our office? _____

Reason for this visit _____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ **First** _____ **Initial** _____ **Marital Status** _____

Address _____ **City** _____ **State/Zipcode** _____

Mailing(if different) _____

Soc. Sec.#(if different) _____ **Birthdate** _____ **Relation to patient** _____

How long at this address _____ **Home Phone** _____ **Cell Phone** _____

Previous address (if less than 3 yrs.) _____

Work Phone _____ **E-Mail** _____

Employer _____ **Occupation** _____ **No. Yrs. Employed** _____

Responsible party's spouse _____

Home phone _____ **Work phone** _____ **Cell phone** _____

EMERGENCY INFORMATION: INDIVIDUAL NOT LIVING WITH YOU

NAME _____ **RELATIONSHIP** _____

ADDRESS _____

HOME PHONE _____ **WORK PHONE** _____ **CELL PHONE** _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____ **Employer** _____

Insurance Co. _____ **Group #** _____ **Local #** _____

Insurance Co. Address _____ **Phone #** _____

The undersigned hereby authorizes the 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 and I will be informed of the fee for dental treatment prior to being treated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments from the insurance carrier will be credited to my account, or refunded to me if I have paid the dental fees incurred. I understand that where appropriate, credit reports may be obtained.

PATIENT Signature (Parent of Child) _____ **Date** _____

PATIENT NAME _____

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone except to medical or dental professionals, as needed. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY

How long since your last dental visit? _____

Last COMPLETE DENTAL EXAM Date: _____

Last FULL MOUTH X-RAYS :(16 SMALL FILMS, OR PANORAMIC)

Date: _____

Are you having problems now: _____?

Do you wear DENTURES? (PARTIALS OR FULL) Yes No

Are you happy with your dentures? Yes No

Would you like to know more about

PERMANENT REPLACEMENTS? Yes No

Are you APPREHENSIVE about dental treatment? Yes No

Have you had any PERIODONTAL (GUM) treatments? Yes No

Do your gums BLEED, are TENDER or IRRITATED? Yes No

Are your teeth SENSITIVE to hot, cold, sweets, pressure?

Yes No

Are you CONCERNED with the APPEARANCE of your teeth?

Yes No

Are you aware of GRINDING or CLENCHING your teeth?

Yes No

Do you have HEADACHES, EARACHES, or NECK PAINS?

or jaw pains? Yes No

Have you worn braces on your teeth? Yes No

Do you have DISCLORED teeth that bother you? Yes No

Would you like your smile to LOOK BETTER or DIFFERENT?

Yes No

Do you REGULARLY use DENTAL FLOSS? Yes No

Name of Previous Dentist:

_____

City:_____ State/Zipcode_____

How do you feel about your teeth? Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment?

Fear of pain #___ Lack of concern #___

Cost of treatment #___ Missing time at work #___

FAMILY PHYSICIAN_____

PHONE _____

Medical History

Do you have CURRENT HEALTH PROBLEMS?_____

Are you under a PHYSICIAN'S CARE NOW? _____

For what? _____

List medications you are taking: _____

_____

Are you pregnant? _____ Due date:_____

Do you use:cigars/cigarettes,pipe or chewing tobacco? ____

Please note if you have or have had any of the following:

	Y	N		Y	N
AIDS/HIV Pos			Fainting		
Anaphylaxis			Food allergies		
Anemia			Heart murmur		
Arthritis			Heart problems		
Artificial heart valve			_____		
Artificial joints			Hemophilia		
Asthma			Herpes		
Back problems			Hepatitis		
Blood disease			High Blood Pressure		
Cancer			Kidney disease		
Chemical dependency			Liver disease		
Chemotherapy			Mitral valve prolapse		
Circulatory problems			Nervous problems		
Cortisone treatments			Pacemaker/heart		
Cough(persistent)			Psychiatric care		
Cough up blood			Epilepsy		
Diabetes			Hypertension		
Skin rash			Rapid weight gain/loss		
Spina Bfida			Radiation treatment		
Stroke			Respiratory disease		
Surgical implant			Rheumatic/scarlet fever		
Swelling feet/ankles			Shingles		
Thyroid Disease			Shortness of breath		
Tonsillitis			Ulcer/Colitis		
Tuberculosis			Venereal disease		
			Other conditions		

Are you allergic to or have you reacted adversely to any of the following medications? Aspirin Local Anesthetic Codeine Erythromycin Latex Gloves Nitrous Oxide Penicillin

ARE YOU AWARE OF BEING ALLERGIC TO ANY OTHER MEDICATIONS OR SUBSTANCES? IF YES, PLEASE LIST:

_____