

Granbury Dental Center

Registration and Health History

PATIENT INFORMATION Name (last) _____ (first) _____ (MI) _____ Sex: M F DOB: / /

Age: _____ SSN: - - Home #: _____ Work #: _____ Cell #: _____

Address: _____ City: _____ State: _____ Zip: _____ E-mail: _____

Reason for visit: _____ Has any family member received treatment in this office? _____

How did you hear about us? _____ What is the best appointment time for you? Morning Afternoon Evening

EMERGENCY CONTACT (relative not living with you) Name: _____

Phone #: _____ Address: _____ City: _____ State: _____ Zip: _____

RESPONSIBLE PARTY Name (last) _____ (first) _____ (MI) _____

Relation to patient: _____ Residence: _____ City: _____ State: _____ Zip: _____

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

How long at this address? _____ Home #: _____ Work #: _____ Cell #: _____

Previous address (if less than 3 yrs.) _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____ # Years Employed: _____

SSN: - - DOB: / / Driver's License #: _____ Marital Status: _____

Spouse Name (last) _____ (first) _____ (MI) _____

Employer: _____ Occupation: _____ # Years Employed: _____

SSN: - - DOB: / / Work Phone #: _____

DENTAL INSURANCE Insured's Name: _____ Insurance Company: _____

Insurance Company Address: _____

Insured's Employer: _____

Insured's SSN: - - Group #: _____ Local #: _____

DENTAL HISTORY It is important for us to know your dental and medical history. These facts have a direct bearing on your Dental Health and will be kept confidential.

How long since you have seen a dentist? _____ Last complete dental examination? (date) _____

Name of previous dentist: _____ City: _____ State: _____ Phone #: _____

How do you feel about your teeth? _____ If you could change anything about your teeth, what would it be? _____

Please rank the following in order in which they would prevent you from having dental treatment (1-4).

Fear of pain # _____ Lack of concern # _____ Cost of treatment # _____ Missing work time # _____

Are you currently having problems? YES NO	Are your teeth sensitive to hot, cold, sweets, pressure? YES NO
What are those problems? _____	Are you unhappy with the appearance of your teeth? YES NO
Is your present dental health poor? YES NO	Are you aware of grinding or clenching your teeth? YES NO
Do you wear dentures (partial or full)? YES NO	Do you have headaches, earaches, or neck pain? YES NO
Are you happy with your dentures? YES NO	Have you worn braces on your teeth (orthodontics)? YES NO
Are you interested in permanent replacements? YES NO	Do you have discolored teeth that bother you? YES NO
Are you apprehensive about dental treatment? YES NO	Would you like your smile to look better or different? YES NO
Have you had any periodontal (gum) treatments? YES NO	Do you regularly use dental floss? YES NO
Do your gums bleed, or feel tender or irritated? YES NO	

GENERAL HEALTH HISTORY Please circle yes or no if you currently suffer from any of the following, and list conditions if necessary:

Cardiovascular disease (heart trouble, heart attack, stroke, coronary insufficiency, damaged coronary heart valves, heart murmur, artificial heart valve)	YES	NO
Kidney trouble	YES	NO
High blood pressure	YES	NO
Low blood pressure	YES	NO
Tuberculosis	YES	NO
Diabetes	YES	NO
Glaucoma	YES	NO
Abnormal bleeding associated with previous surgery, extraction, or trauma	YES	NO
Any condition that would require pre-medication (such as knee/hip replacement)	YES	NO
Any other disease, condition, or problem not listed above that we should know about	YES	NO

Are you currently under a physician's care? YES NO If yes, for what condition? _____

What medications are you currently taking? _____

Are you allergic to, or have you had adverse reactions to any drugs or medications? YES NO

If yes, please list drugs or medications: _____

Women Only: Are you pregnant? YES NO Are you nursing? YES NO

THE EPWORTH SLEEPINESS SCALE *The Epworth Sleepiness Scale (ESS) was developed and validated by Dr. Murray Johns of Melbourne, Australia. It is a simple, self-administered questionnaire, widely used by sleep professionals in quantifying the level of daytime sleepiness.*

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling "just tired"? This refers to your usual way of life at present and in the recent past. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0 = would never doze **1** = slight chance of dozing **2** = moderate chance of dozing **3** = high chance of dozing

SITUATION	SCORE
Sitting and reading	
Watching Television	
Sitting, inactive in a public place	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

Johns MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. Sleep 1991; 14 (6): 540-5

TOTAL: _____

TMJ QUESTIONNAIRE These questions are useful in identifying jaw joint disorders and related headaches.

PLEASE CHECK ALL THAT APPLY:

- | | |
|---|--|
| Do you have difficulty or pain opening your mouth? <input type="checkbox"/> | Do you have either "clicking" or "popping" in either jaw joint? <input type="checkbox"/> |
| Is your jaw stiff, tight, or tired? <input type="checkbox"/> | Do you have headaches or facial pain? <input type="checkbox"/> |
| Do you have difficulty or pain when chewing? <input type="checkbox"/> | Do you clench or grind your teeth during the day or night? <input type="checkbox"/> |

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

you may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please print name: _____

Signature: _____ Date: _____

FOR OFFICE USE ONLY We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining
- An emergency situation prevented us from obtaining
- Other (please specify): _____

RESPONSIBILITY AND CONSENT STATEMENT

Our staff will review this Responsibility and Consent Statement with you before signing.

I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purposes or dental treatment. These records may include study models, photographs, x-rays, and blood studies. I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage. Treatment plans involving extended credit circumstances may have a credit check done on my credit rating. I also understand that the treatment estimate presented to me is only an estimate. Occasionally the need may arise to modify treatment. In such a case, I will be informed of the need for additional treatment, and its fee.

Signature of Patient: _____ Date: _____

Signature of Dentist: _____ Date: _____

FOR OFFICE USE ONLY

Patient Interview: _____

Concerns: _____

Interests: _____

