

PATIENT REGISTRATION HEALTH HISTORY FORM

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION:

DATE _____

PATIENT							
FIRST NAME			INITIAL		LAST NAME		
HOME PHONE #				CELL PHONE #			
ADDRESS				CITY		STATE	ZIP
BIRTHDATE		AGE	SEX F M	SCHOOL (if applicable)		CITY	GRADE
EMPLOYER			BUSINESS ADDRESS		WORK PHONE # /EXT.		SOCIAL SECURITY #
EMAIL ADDRESS							

RESPONSIBLE PARTY (if different from above)							
FIRST NAME			INITIAL		LAST NAME		SOCIAL SECURITY #
HOME PHONE #				CELL PHONE #			
ADDRESS				CITY		STATE	ZIP
BIRTHDATE		AGE	EMPLOYER			WORK PHONE # / EXT.	
OCCUPATION		BUSINESS ADDRESS		CITY		STATE	ZIP

SPOUSE							
FIRST NAME			INITIAL		LAST NAME		SOCIAL SECURITY #
HOME PHONE #				CELL PHONE #			
BIRTHDATE		AGE	EMPLOYER			WORK PHONE # / EXT.	
OCCUPATION		BUSINESS ADDRESS		CITY		STATE	ZIP

DENTAL INSURANCE							
PRIMARY INSURANCE COMPANY				ADDRESS/CITY/STATE/ZIP			
EMPLOYEE		EMPLOYEE ID#		EFFECTIVE DATE		GROUP #	
SECONDARY INSURANCE COMPANY				ADDRESS/CITY/STATE/ZIP			
EMPLOYEE		EMPLOYEE ID#		EFFECTIVE DATE		GROUP #	

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____

ADDRESS _____

PHONE # (home) _____ (cell) _____

IS ANOTHER MEMBER OF YOUR FAMILY A PATIENT AT OUR PRACTICE? YES NO Name _____

WE RESERVE THE RIGHT TO CHARGE FOR APPOINTMENTS CANCELLED OR BROKEN WITHOUT 48 HOURS NOTICE. _____ PLEASE INITIAL

1. Are you in good health? YES NO
2. Are you under the care of a physician? YES NO
- If so, what condition is being treated? _____
- Physician's name _____ Phone _____
- Address _____
3. Have you been hospitalized or had a serious operation or illness within the last 5 years? YES NO
4. Do you have or have you had any of the following diseases or problems? **PLEASE CIRCLE:**

Mitral Valve Prolapse	Yes	No	Cough	Yes	No	Thyroid Disease	Yes	No
Heart Failure	Yes	No	Tuberculosis (TB)	Yes	No	X-ray or Cobalt Treatment	Yes	No
Heart Disease or Attack	Yes	No	Asthma	Yes	No	Chemotherapy (Cancer, leukemia) ..	Yes	No
Angina Pectoris	Yes	No	Hay Fever	Yes	No	Arthritis	Yes	No
High Blood Pressure	Yes	No	Sinus Trouble	Yes	No	Rheumatism	Yes	No
Heart Murmur	Yes	No	Allergies or Hives	Yes	No	Cortisone Medicine	Yes	No
Rheumatic Fever	Yes	No	Artificial Joint	Yes	No	Glaucoma	Yes	No
Congenital Heart Lesions	Yes	No	Anemia	Yes	No	Pain in Jaw Joints	Yes	No
Scarlet Fever	Yes	No	Stroke	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Heart Valve	Yes	No	Kidney Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Heart Pacemaker	Yes	No	Ulcers	Yes	No	Cold Sores	Yes	No
Heart Surgery	Yes	No	Bruise Easily	Yes	No	STD or VD (Syphilis, or Gonorrhea) ..	Yes	No
HIV Positive	Yes	No	Sickle Cell Disease	Yes	No	Blood Transfusion	Yes	No
Hepatitis A (infectious)	Yes	No	Psychiatric Treatment	Yes	No	Liver Disease	Yes	No
Hepatitis B (serum)	Yes	No	Nervousness	Yes	No	Immune System Disorder	Yes	No
Yellow Jaundice	Yes	No	Diabetes	Yes	No			
Emphysema	Yes	No	Lupus	Yes	No			

COMMENTS:

5. Are you taking any drug or medication? YES NO If so, what _____
- 5A. Have you ever taken Phentermine/Pondimin, (Fen/Fen)? YES NO
- 5B. Do you take Coumadin? YES NO
- 5C. Do you take Plavix? YES NO
- 5D. Do you take Aspirin? YES NO
6. Are you allergic or have you reacted adversely to any drugs or medicines? YES NO
- If so, what _____

Aspirin	Erythromycin	Novocaine or Hylocaine	Scopolamine	Valium
Codeine	Local Anesthetic	Penicillin	Sleeping Pills	Latex
Darvon	Nembutal/Seconal	Percodan	Sulfa	
Demerol	Nitrous Oxide	Other Antibiotics	Tetracycline	

7. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest? YES NO
8. Do your ankles swell during the day? YES NO
9. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? YES NO
10. Do you have a disease, condition, or problem not listed above that you think I should know about? YES NO
- If yes, please explain _____
11. Have you had a breast augmentation in the last 12 months? (may require premedication) YES NO
12. FOR WOMEN ONLY: ARE YOU PREGNANT? YES NO
- If yes, what month? _____ Are you taking birth control pills? YES NO
13. Are you happy with the appearance of your smile? YES NO
- What would you change? _____
14. Previous Dentist _____ Phone _____
- Last Full Mouth X-rays taken _____ Are you experiencing pain or discomfort? YES NO
15. Have you had any serious trouble associated with any previous dental treatment? YES NO
- If so, please explain _____

CONSENT: The undersigned hereby authorized Doctor to take radiographs, 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 he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or any dependents is mine, due and payable at the time services are rendered. I further understand that a 1.5% finance charge (18% annually) will be added to any balance over 60 days. In the event of default 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. You are also authorizing messages regarding your appointment to be left on your answering machine or voicemail.

PATIENT _____ DATE _____ WITNESS _____

PARENT OR RESPONSIBLE PARTY _____ RELATIONSHIP TO PATIENT _____

Ben D. Counihan, D.D.S.

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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

