WHITTIER PALM DENTAL
Dr. Jelani Winslow

DENTAL REGISTRATION AND HEALTH HISTORY

Date_____

Patients Name_____ How do you prefer to be addressed?_____

Sex: M F Age:_____ Birth Date:_____/_____/_____ Single Married Widow Separated Divorced SS#_____-_____-_____

Mailing Address_____City_____State_____Zip_____

Home #:_____ Cell#:_____ Work#: _____

Employer:_____ Occupation: _____

If Student, name of School / College:_____ City_____ State_____ Part Time or Full Time

Email Address:_____ Whom may we thank for referring you to our office:_____

If the person responsible for this patients account is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section titled "Insurance Information"

Name of responsible party_____ Relationship to Patient_____

Mailing Address_____City_____State_____Zip_____

Sex: M F Age:_____ Birth Date:_____/_____/_____ Single Married Widow Separated Divorced SS#_____-_____-_____

Home #:_____ Cell#:_____ Work#:_____

Email Address:_____ Employer:_____ Occupation:_____

INSURANCE INFORMATION

Policy Holders Name_____ Relationship to Patient_____

Social Security and/or Member ID #_____ Date of Birth _____/_____/_____

Name of Employer_____ Employer Address_____

Insurance Co._____ Phone #_(_____)_____-_____ Group #_____

Secondary Insurance Information

Policy Holders Name_____ Relationship to Patient_____

Social Security and/or Member ID #_____ Date of Birth _____/_____/_____

Name of Employer_____ Employer Address_____

Insurance Co._____ Phone #_(_____)_____-_____ Group #_____

Answers to the following questions are for our records only and will be considered confidential.

1. Have you or any member of your family been seen by us before? YES NO
   If yes, Which family member (s)?_____
2. Date of last physical examination_____ Physician's name_____
3. *Date of last dental examination* _____ *Date of last dental x-rays*_____
4. Previous Dentist's Name _____ City/ State_____
5. Are you having pain or discomfort at this time? YES NO
6. Do you feel nervous about having dental treatment? YES NO
7. Have you ever had a bad experience in a dental office? YES NO
8. Is there anything you dislike about your smile? YES NO
9. Is there anything you would like to speak with the doctor about in private? YES NO
10. Have you been a patient in the hospital during the past two years? YES NO
11. Have you been under the care of a medical doctor during the past two years? YES NO
12. Have you taken any medications or drugs in the past two years? YES NO
13. Are you taking any vitamins, herbal supplements or "cures"? YES NO
14. Have you ever had excessive bleeding requiring special treatment? YES NO

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ALLERGIES

Aspirin	Local Anesthetic
Barbiturates	Penicillin
Codeine	Sulfa
Iodine	Metals
Latex	Other:_____

MEDICATIONS

Please list any medications you are currently taking:

_____
_____
_____
_____

Place a mark on YES or No to indicate if you have had any of the following:

Chest Pain	YES	NO	Hepatitis A (Infectious)	YES	NO	Use of tobacco products	YES	NO
Heart Failure	YES	NO	Hepatitis B (Serum)	YES	NO	Drug addictions	YES	NO
Heart Disease or Attack	YES	NO	Hepatitis C or other	YES	NO	Alcoholism	YES	NO
Heart Problems	YES	NO	Tuberculosis (TB)	YES	NO	Psychiatric Treatment	YES	NO
Heart Surgery	YES	NO	HIV positive, ARC, AIDS	YES	NO	Mental Retardation	YES	NO
*Mitral Valve Prolapse	YES	NO	*Sickle Cell Disease*	YES	NO	*Birth Defects*	YES	NO
*Congenital Heart Problems	YES	NO	Emphysema	YES	NO	Eating Disorder	YES	NO
*Heart Murmur	YES	NO	Diabetes	YES	NO	Fainting or dizzy spells	YES	NO
High Blood Pressure	YES	NO	Liver Disease	YES	NO	Epilepsy or seizures	YES	NO
Heart Pacemaker	YES	NO	Thyroid Disease	YES	NO	Persistent Cough	YES	NO
Stroke	YES	NO	Kidney Trouble	YES	NO	Asthma	YES	NO
Cancer (Type:)	YES	NO	Hemophilia	YES	NO	Shortness of Breath	YES	NO
Radiation Therapy	YES	NO	Jaundice	YES	NO	Hay Fever	YES	NO
Chemotherapy	YES	NO	Anemia	YES	NO	Hives or Skin Rash	YES	NO
*Steroid Treatment	YES	NO	Glaucoma	YES	NO	Sinus Trouble	YES	NO
*Artificial Joints	YES	NO	Arthritis	YES	NO	Herpes	YES	NO
*Any Type of Transplant	YES	NO	Ulcers	YES	NO	Cold Sores	YES	NO
*Any Type of Implant	YES	NO	Angina Pectoris	YES	NO	Bruise Easily	YES	NO
*Rheumatic Fever	YES	NO	Blood Transfusion	YES	NO	Dentures or Partials	YES	NO

OTHER:_____

*Antibiotic pre-medication may be required prior to your appointment

Have you been advised by your Physician to "Pre-Medicate" for dental appointments? YES NO

Have you ever experienced any of the following problems with your jaw:

Clicking	YES	NO
Pain in or around your ears	YES	NO
Difficulty opening or closing	YES	NO
Do you have a history of trauma to your jaw?	YES	NO
Have you ever been diagnosed with TMJ/TMD?	YES	NO

Do you currently have any of the problems listed below? Please circle all that apply:

Swelling Bad Taste
Bleeding Gums Loose Teeth
Sensitive to:
Hot Cold
Biting/ Pressure Sweets
Other:_____

Do you have any sores or lumps or growths in or near your mouth?	YES	NO	Problems with bad breath? (Halitosis)	YES	NO
Have you ever had difficult extractions in the past?	YES	NO	Do you have any trouble chewing?	YES	NO
Have you ever had prolonged bleeding following extractions?	YES	NO	Does food collect between your teeth?	YES	NO
Are there now any growths or sores in or around your mouth?	YES	NO	Have you ever had instructions in oral hygiene?	YES	NO
Do you habitually clench or grind your teeth during the day or night?	YES	NO	Have you ever taken Redux or Pondimin (Fen Phen)?	YES	NO

Have you ever been told you have gum problems?	YES	NO
Have you ever needed to see a periodontist?	YES	NO
Do you now have bleeding gums or any other gum condition?	YES	NO
Is there anything related to your medical or dental history tat you have not indicated above?	YES	NO

If yes, please explain:_____

WOMEN: Are you pregnant now?	YES	NO	If yes, what is your due date?_____
Are you currently breast feeding?	YES	NO	
Are you taking oral contraceptives?	YES	NO	

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/ or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ Date:_____

Signature of patient or guardian