

# Health History & Registration

## Michael J. Neeley DDS

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Phone # 214-521-3148

Who may we thank for referring You to our Office?

\_\_\_\_\_ Today's Date

### Patient Information

\_\_\_\_\_  
Patient's Name First Middle Last Nickname

\_\_\_\_\_  
Date of Birth Male or Female Social Security # / Drivers License # - State

\_\_\_\_\_  
Patient Address Street City State Zip Code

\_\_\_\_\_  
Phone # Home Cell Work Phone

Which number do you want us to confirm your dental appointments? \_\_\_\_\_

Comments: \_\_\_\_\_ E-Mail address \_\_\_\_\_

### Insurance Information

\_\_\_\_\_  
Insurance Company Name Insurance 1-800 # Group #

\_\_\_\_\_  
Insurance Company Address City State Zip Code

\_\_\_\_\_  
Employer of Subscriber Phone

\_\_\_\_\_  
Subscriber name (if different from ptc) Date of Birth Insurance ID #

\_\_\_\_\_  
Subscriber phone # Cell Home Work

Who can we contact in case of an emergency?

\_\_\_\_\_  
Name Relation Cell # Phone #

# Health History & Registration

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. Thank you for taking the time to completely fill out this questionnaire. **Dr. Michael J. Neeley**

## Dental History

HOW LONG SINCE you have seen a dentist? _____	Yes	No	Comments:
Are you having <b>PROBLEMS</b> now?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is your present dental health <b>POOR</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you <b>APPREHENSIVE</b> about dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had any <b>PERIODONTAL (GUM)</b> treatments?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do your gums <b>BLEED</b> when you floss?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are your teeth <b>SENSITIVE</b> to hot, cold, sweets, pressure? (please circle)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you <b>UNHAPPY</b> with the <b>APPEARANCE</b> of you teeth?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you aware of <b>GRINDING</b> or <b>CLEANCHING</b> your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have <b>HEADACHES, EARACHES, or NECK PAINS</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you worn Braces on your teeth ( <b>ORTHODONTICS</b> )	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have <b>DISCOLORED</b> teeth that bother?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Would you like your smile to <b>LOOK BETTER</b> or <b>DIFFERENT</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you <b>REGULARLY</b> use <b>DENTAL FLOSS</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Name of previous Dentist: \_\_\_\_\_ Phone \_\_\_\_\_  
 City: \_\_\_\_\_ State \_\_\_\_\_

Please **RANK** the following in the order in which they would **KEEP YOU FROM** dental treatment.

**FEAR** of pain # \_\_\_\_\_ **LACK** of concern # \_\_\_\_\_  
**COST** of treatment # \_\_\_\_\_ **MISSING** work time # \_\_\_\_\_

## Medical History

	Yes	No	
Do you have any <b>CURRENT HEALTH PROBLEMS</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you under a <b>PHYSICIAN'S CARE</b> now?	<input type="checkbox"/>	<input type="checkbox"/>	
For what? _____			
What <b>MEDICATIONS</b> are you currently taking? _____			
Are you <b>PREGNANT</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you use cigars/cigarette, pipe, or chewing tobacco? (please circle)	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Please check of the following which you have had or presently have:</b>			
AIDS/HIV Pos. <input type="checkbox"/>	Hemophilia(abnormal bleeding) <input type="checkbox"/>	Other: _____	
Anaphylaxis shock <input type="checkbox"/>	Herpes <input type="checkbox"/>	_____	
Arthritis <input type="checkbox"/>	Hepatitis <input type="checkbox"/>	_____	
Artificial heart valves <input type="checkbox"/>	High Blood Pressure <input type="checkbox"/>	_____	
Artificial joints <input type="checkbox"/>	Jaw Pain <input type="checkbox"/>	_____	
Asthma <input type="checkbox"/>	Kidney disease or malfunction <input type="checkbox"/>	<b>Comments on Health:</b> _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	
Cancer <input type="checkbox"/>	Liver disease <input type="checkbox"/>		
Chemical dependency <input type="checkbox"/>	Mitral valve prolapse <input type="checkbox"/>		
Chemotherapy <input type="checkbox"/>	Pacemaker/heart surgery <input type="checkbox"/>		
Circulatory problems <input type="checkbox"/>	Radiation treatment <input type="checkbox"/>		
Cortisone treatments <input type="checkbox"/>	Respiratory disease <input type="checkbox"/>		
Diabetes <input type="checkbox"/>	Shortness of Breath <input type="checkbox"/>		
Epilepsy <input type="checkbox"/>	Stroke <input type="checkbox"/>		
Fainting <input type="checkbox"/>	Tuberculosis <input type="checkbox"/>		
Heart murmur <input type="checkbox"/>	Headaches <input type="checkbox"/>		
Heart problems <input type="checkbox"/>			

**ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?**

Asprin \_\_\_\_\_ Local Anesthetic \_\_\_\_\_ Erthromycin \_\_\_\_\_ Latex \_\_\_\_\_ Nitrous Oxide \_\_\_\_\_ Codeine \_\_\_\_\_ Penicillin \_\_\_\_\_  
 Are you aware of being allergic to any other medications or substances? If yes please list \_\_\_\_\_

**Family Physician** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**PATIENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_