WERSCHKY & LEWIS
family dentistry

HEALTH HISTORY & REGISTRATION

PATIENT INFORMATION (PLEASE PRINT)

Date _____

Last Name_____ First Name _____ M.I. _____ Preferred Name_____ Birth Date_____
Address_____ City, State, Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____ Soc Sec # _____
Sex: □ M □ F Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed
I would like to receive correspondences by text □ Y □ N

RESPONSIBLE PARTY INFORMATION (If not the patient)

Last Name_____ First Name _____M.I. _____Birth Date _____ Sex: □ M □ F
Address _____ City, State, Zip _____ Soc Sec # _____
Home Phone _____ Work Phone _____ Cell Phone _____

PRIMARY DENTAL INSURANCE

Name of Insured_____ Relationship to Insured: □ Self □ Spouse □ Child □ Other
Insurance Company _____ Subscriber ID# _____ Group # _____
Insurance Phone #_____ Employer Name _____ Birth Date _____

SECONDARY DENTAL INSURANCE

Name of Insured_____ Relationship to Insured: □ Self □ Spouse □ Child □ Other
Insurance Company _____Subscriber ID# _____ Group # _____
Insurance Phone #_____ Employer Name _____ Birth Date _____

EMERGENCY INFORMATION: (Closest relative not living with you)

Name: _____ Phone Number _____
Address _____ City, State, Zip _____

GETTING TO KNOW YOU

Whom may we thank for referring you? _____
Is another member of your family or relative a patient at our office? If so, who? _____

DENTAL HISTORY

Previous Dentist_____ City / State_____
Reason for today's visit? _____
Date of last dental visit? _____ Last dental cleaning? _____ Last full mouth X-rays? _____
How often do you brush your teeth? _____ Floss? _____

Please check the boxes below to indicate if you have or had any of the following:

- □ A Bite Plate or Mouth Guard
- □ A Serious Injury to the Mouth or Head
- □ Bad Breath
- □ Bleeding Gums
- □ Blisters on Lips or Mouth
- □ Burning Sensation of Tongue
- □ Clicking or Popping of Jaw
- □ Cigarette, Pipe or Cigar Smoking
- □ Chewing Tobacco
- □ Difficulty in opening or closing the mouth
- □ Dry Mouth
- □ Fingernail Biting
- □ Food Collection between Teeth
- □ Grinding Teeth
- □ Hold Foreign Objects with Teeth?
- □ Jaw Pain or Tiredness
- □ Lip or Cheek Biting
- □ Loose Teeth and/or Broken Filling
- □ Mouth Breathing
- □ Oral Surgery
- □ Periodontal Treatment
- □ Sensitivity to Sweets
- □ Sensitivity to Temperature
- □ Sensitivity when Biting
- □ Sores or Growths in Mouth
- □ Swollen Gums
- □ Your Teeth Ground or the Bite Adjusted

Do you / have you ever experienced pain or discomfort in your jaw?_____ Do you like your smile?_____
Have you ever had a serious or difficult problem associated with previous dental work?_____
Have your parents experienced gum disease or tooth loss?_____ Do you have any dental problems, pain or discomfort at this time? If yes please describe_____

Patient Name_____

HEALTH HISTORY

Do you have any allergies? Please List:_____

Please list medications you are currently taking including any holistic medicines and / or blood thinners_____

_____

Pharmacy Name_____ City_____ Phone number_____

Please check the boxes below to indicate if you have or had any of the following:

- □ AIDS / HIV positive
- □ Allergies or Hives
- □ Alzheimer's Disease
- □ Anaphylaxis
- □ Anemia
- □ Angina
- □ Arthritis / Gout
- □ Artificial Heart Valves
- □ Artificial Joints
- □ Asthma
- □ Back Problems
- □ Blood Disease
- □ Blood Transfusion
- □ Breathing Problems
- □ Bruise Easily
- □ Cancer
- □ Chemotherapy
- □ Chest Pains
- □ Circulatory Problems
- □ Cold Sores / Fever Blisters
- □ Congenital Heart Disorder
- □ Convulsions
- □ Cortisone Treatments
- □ Cough (Persistent or Bloody)
- □ Diabetes (Type I or Type II)
- □ Eating Disorder
- □ Emphysema
- □ Epilepsy or Seizures
- □ Excessive bleeding
- □ Excessive thirst
- □ Fainting Spells / Dizziness
- □ Glaucoma
- □ Hay Fever
- □ Headaches
- □ Heart Attack / Failure
- □ Heart Disease
- □ Heart Murmur
- □ Heart Pacemaker
- □ Heart Problems
- □ Hemophilia
- □ Hepatitis A, B or C
- □ Herpes
- □ Hiatal Hernia
- □ High Blood Pressure
- □ High Cholesterol
- □ Hypoglycemia
- □ Irregular Heartbeat
- □ Jaundice
- □ Joint Replacement
- □ Kidney Disease
- □ Kidney Transplant
- □ Leukemia
- □ Liver Disease
- □ Low Blood Pressure
- □ Lung Disease
- □ Lupus
- □ Mitral Valve prolapse
- □ Nervous Problems
- □ Neurological Disorders
- □ Osteoporosis
- □ Pacemaker
- □ Parathyroid Disease
- □ Psychiatric Care
- □ Radiation Treatment
- □ Renal Dialysis
- □ Respiratory Disease
- □ Rheumatic Fever
- □ Rheumatoid Arthritis
- □ Scarlet Fever
- □ Shingles
- □ Shortness of Breath
- □ Sickle Cell Disease
- □ Sinus Trouble
- □ Skin Rash
- □ Special Diet
- □ Steroids / Cortisone Medicine
- □ Stomach / Intestinal Disease
- □ Stroke
- □ Swelling of the Feet or Ankles
- □ Swollen Neck Glands
- □ Thyroid Disease
- □ Tonsillitis
- □ Tuberculosis
- □ Tumors or Growths
- □ Ulcers
- □ Venereal Disease
- □ Yellow Jaundice

Do you have or have you had any disease, condition, or problem not listed?_____ If yes, Please list:_____

_____

Women : Are you pregnant? _____ Due Date _____ Are you nursing?_____

Are you taking birth control pills? _____

Do you have any further questions, concerns or additional information or Is there anything else about having dental treatment that you would like us to know? _____ If yes, Please describe:_____

_____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquired set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: _____Reviewed by: _____ Date:_____