

Gorham Family Dentistry, P.A.
18 Park Street
Gorham, NH 03581

PATIENT REGISTRATION:

Patient's Name: _____ Birth Date: _____ SS # _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Home Phone Number: _____

Employer: _____ Work Phone Number: _____

Email Address: _____ Cell Phone Number: _____

Preferred Method of Contact: _____

Previous Dentist: _____ Last visit: _____

Physician: _____ Phone: _____ Last Visit: _____

Marital Status: _____ Name of Spouse: _____ Birth Date: _____

If a Minor, Guardian's Name and relationship: _____

Emergency Contact: _____ Relationship _____ Phone # _____

Responsible Party's Name: _____ Birth Date _____ SS# _____

Responsible Party's Address: _____

City: _____ State: _____ Zip: _____ Phone Number _____

DENTAL INSURANCE:

Subscriber's Name: _____ Birth Date _____ ID # _____

Employer: _____ Group # _____

Insurance Company: _____ Phone _____

Address: _____ City: _____ State _____ Zip _____

Insurance Release:

I authorize Gorham Family Dentistry to release to my insurance company any information relating to any and all insurance claims for treatment received. I authorize payment of dental benefits otherwise payable to me directly to Gorham Family Dentistry. I understand that I am financially responsible for any balance not paid my insurance company within 60 days of treatment.

Signed: _____ Date: _____

PURPOSE OF THIS APPOINTMENT: _____

Whom may we thank for referring you: _____

Cancellation Policy: Gorham Family Dentistry views all appointments as a commitment between our patients and us. If you are unable to honor the commitment, we request 2 business days notice to allow another patient who is waiting for that time to be scheduled. If two appointments are not kept without the patient giving 2 business days notice in a twelve-month period the patient agrees to pay a fee equal to the greater of \$50 or 15% of the cost of the planned treatment. If three appointments are not kept without the patient giving 2 business days notice in a twelve-month period, Gorham Family Dentistry reserves the right to terminate the patient-doctor relationship.

Financial Policy: Payment is due when services are rendered. If you have insurance and we are able to estimate your insurance benefits, only the estimated co-payment is due when services are rendered. If insurance pays less than estimated, the patient is financially responsible for the balance. Payment is due within 30 days of the first statement sent for the balance.

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested.

Signature of Responsible Party

Date

Gorham Family Dentistry
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HEALTH HISTORY:

The following questions are for our records only. They are considered confidential and will become part of your permanent record

Please circle YES or NO for each question. If in doubt, leave blank.

1. Are you in good health? YES NO
2. Has there been a change in you health within the last year.....YES NO
3. Are you presently under the care of a physician?YES NO
4. Have you ever had any serious trouble associated with previous dental treatment? YES NO
5. Does dental treatment make you nervous? NO____Slightly____ Moderately____ Extremely_____
6. **WOMEN:** Are you pregnant? If yes, how far along? _____
7. Do you use tobacco in any form? If yes, how much? _____
8. Do you use alcoholic beverages (more than 2 drinks daily)_____

Do you have or have you had any of the following?

GENERAL

- Tire easily, weakness YES NO
- Marked weight change YES NO
- Night sweats..... YES NO
- Persistent fever..... YES NO

SKIN

- Eruptions (rash) hives YES NO
- Change in skin color YES NO

EYES

- Visual change..... YES NO
- Glaucoma..... YES NO

EARS

- Loss of hearing..... YES NO
- Ringing in ears YES NO

NOSE

- Frequent nose bleeds..... YES NO
- Sinus Problems YES NO

THROAT

- Soreness/hoarseness..... YES NO

NERVOUS SYSTEM

- Stroke..... YES NO
- Headaches YES NO
- Convulsions/Epilepsy YES NO
- Numbness/tingling YES NO
- Dizziness/fainting YES NO
- Psychiatric Treatment YES NO

RESPIRATORY

- Tuberculosis..... YES NO
- Emphysema..... YES NO
- Asthma/hay fever..... YES NO
- Persistent cough YES NO
- Sputum production..... YES NO
- Cough up bloody sputum YES NO
- Difficulty breathing while lying down..... YES NO

ENDOCRINE

- Diabetes YES NO
- Family history of diabetes..... YES NO
- Thyroid condition/goiter YES NO
- Other_____

HEART/BLOOD VESSELS

- Rheumatic Fever.....YES NO
- Heart MurmurYES NO
- Chest pain/discomfort.....YES NO
- Heart Attack/troubleYES NO
- Shortness of breathYES NO
- Swelling of anklesYES NO
- High Blood Pressure.....YES NO
- Congenital Heart DiseaseYES NO
- Mitral Valve Prolapse.....YES NO
- Artificial heart valve.....YES NO
- Pacemaker.....YES NO
- Heart Surgery.....YES NO
- Other_____

BONE/MUSCLE

- Arthritis/rheumatism.....YES NO
- Artificial joints/ limbs.....YES NO
- Placement of Pins or rodsYES NO

DIGESTIVE SYSTEM

- Hepatitis.....YES NO
- JaundiceYES NO
- Ulcers.....YES NO
- Change in appetiteYES NO

URINARY

- Kidney DiseaseYES NO
- Increased urine productionYES NO
- Burning on urination.....YES NO
- Urethral discharge.....YES NO
- Bloody UrineYES NO
- Venereal DiseaseYES NO

BLOOD

- Bruise easilyYES NO
- AnemiaYES NO
- Blood TransfusionYES NO

OTHER

- Radiation therapy.....YES NO
- Chemotherapy.....YES NO
- Tumors or growths.....YES NO
- Cancer.....YES NO
- HIV or AIDSYES NO

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HEALTH HISTORY (p.2):

10. Are you **ALLERGIC** to or have you experienced a reaction to any of the following?

Local Anesthesia (e.g. Novocain).....	YES	NO	Aspirin or Codeine.....	YES	NO
Barbiturates/sedatives/sleeping pills.....	YES	NO	Sulfa Drugs.....	YES	NO
Penicillin.....	YES	NO	Other allergies.....	_____	

11. Are you **CURRENTLY TAKING** any of the following medications?

Antibiotics/Sulfa drugs.....	YES	NO	Insulin/other diabetes drug.....	YES	NO
Blood thinners.....	YES	NO	Osteoporosis medication	YES	NO
Blood pressure medications.....	YES	NO	Digitalis/other heart medication.....	YES	NO
Cortisone/steroids.....	YES	NO	Nitroglycerin.....	YES	NO
Antihistamine/allergy drugs/cold medications..	YES	NO	Aspirin.....	YES	NO
Tranquilizers.....	YES	NO	Other medications.....	YES	NO

Please list any medications (prescription and non-prescription) and the dosage that you take regularly:

12. Have you ever been treated for periodontal disease (gum disease, pyorrhea, or trench mouth)?

If so, when? _____

13. Do you have or have you had any of the following?

MOUTH

Bleeding sore gums.....	YES	NO	Sensitive to hot.....	YES	NO
Unpleasant taste/bad breath.....	YES	NO	Sensitive to cold.....	YES	NO
Burning tongue/lips.....	YES	NO	Sensitive to sweets.....	YES	NO
Frequent blisters, lips/ mouth.....	YES	NO	Sensitive to biting.....	YES	NO
Orthodontic treatment (braces).....	YES	NO	Food impaction.....	YES	NO
Biting cheeks/lips.....	YES	NO	Clenching/grinding.....	YES	NO
Clicking/popping jaw.....	YES	NO	Shifting of teeth.....	YES	NO
Difficulty opening/closing jaw.....	YES	NO	Change in bite.....	YES	NO

14. Please Rate your Smile on a scale of 1-10 _____

15. Are you interested in straightening your teeth?..... YES NO

16. Are you interested in Cosmetic procedures, such as tooth whitening?..... YES NO

ORAL HYGIENE

Do you use the following?

Toothbrush.....	YES	NO	How often do you brush? _____
Dental floss.....	YES	NO	Frequency of dental cleanings: _____
Rubber tip.....	YES	NO	Date of last cleaning: _____
Other.....	Your toothbrush is: SOFT MEDIUM HARD		

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or changes in my medications, I will inform the dentist at the next appointment.

Signature of Patient, Parent, or Responsible Party

DATE