DR. SUPERTOOTH

Stephen J. Howard, DDS, MScD, FASDC

DENTISTRY & ORTHODONTICS

REGISTRATION AND HEALTH HISTORY

Please complete this form in its entirety. Thank You.

DATE _____ SOCIAL SECURITY NO. _____

NAME _____ (Last) _____ (First) _____ (Middle)

ADDRESS _____

PHONE _____ BUSINESS ADDRESS _____ PHONE _____

DATE OF BIRTH _____ SEX _____ HEIGHT _____ WEIGHT _____ OCCUPATION _____

MARITAL STATUS (check) _____ SINGLE _____ MARRIED _____ WIDOWED _____ DIVORCED

SPOUSE'S NAME _____

TYPE OF DENTAL INSURANCE (If applicable) _____ SUBSCRIBER'S SOCIAL SECURITY NO. _____

REFERRED BY _____ SUBSCRIBER'S DATE OF BIRTH _____

MEDICAL HEALTH

General health (please check): EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐

Name and address of physician _____

Last complete physical? _____

Are you taking any medication now? Yes ☐ No ☐ For what purpose? _____

Have you ever been treated for:

Heart disease	Yes ☐	No ☐	Heart murmur	Yes ☐	No ☐
Rheumatic fever	Yes ☐	No ☐	Jaundice	Yes ☐	No ☐
Abnormal blood pressure	Yes ☐	No ☐	Asthma or hay fever	Yes ☐	No ☐
Ulcers	Yes ☐	No ☐	Sinus trouble	Yes ☐	No ☐
Tuberculosis or lung disease	Yes ☐	No ☐	Cough	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐
Epilepsy	Yes ☐	No ☐	Arthritis	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Congenital heart lesions	Yes ☐	No ☐	Glaucoma	Yes ☐	No ☐

Have you ever been treated (other than diagnostic) with x-rays? Yes ☐ No ☐

Are you allergic to: Penicillin ☐ Codeine ☐ Local injected anesthetics ☐ Other medications ☐ _____

Are you subject to prolonged bleeding Yes ☐ No ☐

Are you subject to fainting spells? Yes ☐ No ☐

Do you have excessive urination and/or thirst Yes ☐ No ☐

(women)

Are you pregnant? Yes ☐ No ☐ How long? _____

BIBBERO SYSTEMS, INC. • PETALUMA, CA • © 06/01 (MC42995.02-01)

Reason for visit: _____

When was your last dental visit? _____

Have you ever had any serious problem associated with previous dental treatment? . . . . . Yes ☐ No ☐

If so, explain: _____

_____

How often do you brush your teeth? _____

What texture brush do you use? SOFT ☐ MEDIUM ☐ HARD ☐ NYLON ☐ NATURAL ☐

How often do you floss? _____

Do your gums bleed while brushing? . . . . . Yes ☐ No ☐

Do your gums bleed when flossing? . . . . . Yes ☐ No ☐

Do you avoid brushing any part of your mouth because of pain? . . . . . Yes ☐ No ☐

If yes, what part? _____

Do you feel twinges of pain when your teeth come in contact with:

a) hot foods or liquids, *i.e.,* soup, coffee, tea, etc.? . . . . . Yes ☐ No ☐

b) cold foods or liquids *i.e.,* ice cream, cold fruit, etc.? . . . . . Yes ☐ No ☐

c) sweets, *i.e.,* candy, fruit, sweet desserts, etc.? . . . . . Yes ☐ No ☐

d) sours, *i.e.,* lemons, limes, grapefruit, etc? . . . . . Yes ☐ No ☐

Do you feel pain to any of your teeth when brushing or flossing them? . . . . . Yes ☐ No ☐

Do you chew on only one side of your mouth? . . . . . Yes ☐ No ☐

If yes, explain: _____

_____

Do your gums feel tender or swollen? . . . . . Yes ☐ No ☐

Do you clench or grind your jaws while sleeping or during the day? . . . . . Yes ☐ No ☐

Do your jaws ever feel tired? . . . . . Yes ☐ No ☐

Do you wear dentures? . . . . . Yes ☐ No ☐

Do you usually have many cavities? . . . . . Yes ☐ No ☐

Do you lose filings or break filings? . . . . . Yes ☐ No ☐

Do you gag easily? . . . . . Yes ☐ No ☐

Are you familiar with the term "preventive dentistry"? . . . . . Yes ☐ No ☐

Please add anything you feel is important: _____

_____

_____

_____

_____

_____

_____

I understand that it is my responsibility to pay for dental services provided in this office for today's treatment and all future treatments. Payment is due and payable at the time services are rendered unless other arrangements have been made. If dental insurance is in force I will pay my co-payment at the time services are rendered.

_____

(Patient signature)