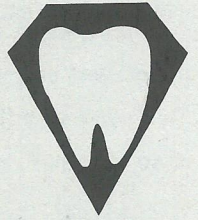


DR. SUPERTOOTH

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 <input type="checkbox"/>	No <input type="checkbox"/>	Heart murmur	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Rheumatic fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Jaundice	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Abnormal blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Asthma or hay fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Ulcers	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sinus trouble	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Tuberculosis or lung disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Cough	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hepatitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Arthritis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Congenital heart lesions	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Glaucoma	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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 (women) Yes No How long? _____

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 fillings or break fillings? 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)