FINGERET DENTAL
FAMILY & COSMETIC DENTISTRY

Registration and Health History

Date:_____

First Name: _____ M.I.: ___ Last Name: _____

Sex: ◉M ○F DOB:_____ Age:_____

Address:_____

City: _____ State: _____ Zip: _____

Home Phone : _____ Work Phone:_____ Cell Phone:_____

Email:_____ Social Security #:_____

Emergency Contact:_____

Marital Status: ◯M ◯S ◯D ◯W Student: ◯Full Time ◯Part Time ◯N/A

Occupation:_____ What would you prefer to be called?: _____

Who may we thank for this referral?: _____

Family Physician: _____ Phone Number: _____

Dental Insurance Carrier: _____ ID:_____

Group #: _____

□ Check this box only if the insured person (the person receiving dental services) is the same as above. If not, enter insured's info below.

Name of Insured:_____ Insured's SS#:_____

Insured's DOB: _____ Relationship to Insured:_____

Employer of Insured:_____ ⊖ Full-Time ⊖ Part-Time ⊖ Retired

Phone #:_____

Who is financially responsible for this account?:_____ Phone:_____

Please select Y = Yes or N= No if you have any of the following conditions:

⊖ Y ⊖ N Rheumatic Fever	⊖ Y ⊖ N Thyroid Disease	⊖ Y ⊖ N Seizure Disorder
⊖ Y ⊖ N Heart Disease	⊖ Y ⊖ N Anemia	⊖ Y ⊖ N Kidney Disease
⊖ Y ⊖ N Heart Murmur (or MVP)	⊖ Y ⊖ N Asthma	⊖ Y ⊖ N Venereal Disease
⊖ Y ⊖ N High Blood Pressure	⊖ Y ⊖ N Diabetes	⊖ Y ⊖ N Bleeding Problems
⊖ Y ⊖ N Tuberculosis	⊖ Y ⊖ N Are you nursing?	⊖ Y ⊖ N Cancer
⊖ Y ⊖ N Use Oral Contraceptives	⊖ Y ⊖ N Might you be pregnant?	⊖ Y ⊖ N AIDS/HIV
⊖ Y ⊖ N Artificial Joint/Heart Valve	⊖ Y ⊖ N Hepatitis Type ○A ○B ○C	⊖ Y ⊖ N Eating Disorders
⊖ Y ⊖ N History of Endocarditis	⊖ Y ⊖ N Radiation Therapy: Head/Neck	

Have you ever been told to pre-medicate with antibiotics? If so, why? _____

Other conditions not listed: _____

_____

Are you allergic to latex, soy or egg products?: _____

List any antibiotics, anesthetics or other drugs you are allergic to: _____

_____

(over)

List all prescription medications you are currently taking: _____

_____

_____

Do you have any disease, organ transplant, or take any medication which may depress your immune system?: _____

Do you have, or have you ever had, clicking, popping, or pain in your tempromandibular joints (TMJ)?:

_____

Have you been hospitalized in the past five years? ◯Y◯N If yes, why?: _____

_____

Do you take an aspirin on a daily basis? ○ Y ○ N If yes, why?:_____

Are you under a physician's care presently? ○ Y ○ N If yes, why?: _____

_____

Have you ever been a drug or substance abuser? ○ Y ○ N

Do you smoke? ○ Y ○ N How much?: _____

Is there anything you would like to discuss with the doctor in private? _____

What is your favorite band/who is your favorite singer? _____

I attest that I understand and answered all the above questions honestly and completely. I understand that the doctor is basing his treatment on this information. I authorize the release of information to insurance carriers and other health care professionals who are involved in my care. I assign my insurance benefits to Andrew I. Fingeret D.M.D. unless otherwise indicated.

Signature: _____

Date: _____

*Your signature indicates you have read the HIPAA law as well as releasing Dr. Fingeret to utilize any dental photographs at his discretion.