



PATIENT REGISTRATION & HEALTH HISTORY FORM

Irvington Professional Building: 2525 NE Broadway, Suite 200, Portland, OR 97232
New Patients: (503) 506-7933 Existing Patients: (503) 234-7870 Fax: (503) 236-9001

Date: _____

PATIENT INFORMATION

First Name: _____ M: _____

Last Name: _____

Preferred Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____

Gender: _____ Is the patient a minor? Yes

Relationship Status: Single Partnered Married

Divorced Widowed

Is the patient a student? Full Time Part Time

Employer: _____

Phone: _____

Occupation: _____

Employer Address: _____

Spouse's Name: _____

Date of Birth: _____

How did you hear about us?: _____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to patient: _____

Insurance Co: _____

Group #: _____

Subscriber ID/SSN: _____

Is patient covered by additional insurance? Yes No

Subscriber's Name: _____

Date of Birth: _____

Relationship to patient: _____

Insurance Co: _____

Group #: _____

Subscriber ID/SSN: _____

ASSIGNMENT AND RELEASE. I certify that I, and/or my dependents have insurance coverage with _____ and assign directly to NE Dental Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above name dental practice may use my health care information and may disclose such information to the above named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date

Relationship to Patient

CONTACT INFORMATION *REQUIRED INFORMATION*

*Cell Phone (_____) _____ Is it okay to send text messages for appointment confirmations and reminders? Yes No

*Email Address: _____ This is used for appointment reminders/confirmations. This is never used for spam or given out to anyone else.

Home Phone (_____) _____ Work Phone (_____) _____ Best time and place to reach you: _____

Emergency Contact: Name _____ Relationship _____ Phone (_____) _____

DENTAL HISTORY

Reason for today's visit: _____

Date of last dental visit: _____

Date of last dental X-rays: _____

Do you have bleeding gums? Yes No

Do you use any form of tobacco?

Do you have dry mouth?

Does food collect between your teeth?

Do you grind your teeth?

Any loose teeth or fillings?

Do you have any jaw pain?

SMILE EVALUATION

Would you like your teeth to be straighter? Yes No

Would you like your teeth to be whiter?

Have you noticed any wear or chipping of your teeth?

If there is anything you could change about your teeth, what would it be?

SLEEP HEALTH

Do you snore? Yes No

Do you wakeup not feeling refreshed?

Do you wakeup in the morning with headaches?

Is it hard to stay awake during the day?

HEALTH HISTORY

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Herpes
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis, Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Nervous System Problems
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care
<input type="checkbox"/>	<input type="checkbox"/>	Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disease
<input type="checkbox"/>	<input type="checkbox"/>	Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Treatments	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Neck Glands
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	<input type="checkbox"/>	Fainting or dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Tumor or growths on head
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis Type _____			

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valves
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding After Surgery
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Lesions
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur
<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Premedication needed for dental visits?
<input type="checkbox"/>	<input type="checkbox"/>	Are You Pregnant?

Other Heart Problems: _____

Other Medical Conditions: _____

MEDICATIONS

Please list any medications that you are currently taking:

Physician Name: _____

Physician Location: _____

Physician Phone: _____

ALLERGIES

	Yes	No
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>
Iodine	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>
Local Anesthetic	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
Reaction to metals	<input type="checkbox"/>	<input type="checkbox"/>

Other/Details: _____

The undersigned hereby authorizes the doctors and staff at NE Dental Associates to perform dental exams, take x-rays, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize the doctors at NE Dental Associates to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize the use of anesthetics and understand that use of anesthetics embodies a certain risk.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Sign here: _____ Date: _____

Doctor: _____ Date: _____