Patient's Cell Phone

Patient's Email

HEALTH HISTORY & REGISTRATION

PATIENT INFORMATION

Patient's Social Security (SS#) _____ DL # _____ County _____

PATIENT'S NAME Last _____ First _____ Middle Initial ____ SEX M F BIRTHDATE _____ AGE ____

If Patient is a Minor, give Parent's or Guardian's Name _____ Reason for this visit _____

Who May We Thank for Referring You to our Office? _____ TODAY'S DATE _____

RESPONSIBLE PARTY INFORMATION

Person Who Brings in Patient

NAME Last _____ First _____ Middle _____ MARITAL STATUS _____

RESIDENCE Street _____ City _____ State _____ Zip _____

HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

PREVIOUS ADDRESS (if less than 3 yrs.) Street _____ City _____ State _____ Zip _____

SS# _____ BIRTHDATE _____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ NO. YEARS EMPLOYED _____

SPOUSE'S NAME Last _____ First _____ Middle _____ WORK PHONE _____

EMPLOYER _____ SS# _____ BIRTHDATE _____ RELATIONSHIP TO PATIENT _____

EMERGENCY INFORMATION: (Person to contact in emergency)

Name _____

Address _____

Phone _____

(NEAREST RELATIVE NOT LIVING WITH YOU)

Name _____

Address _____

Phone _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Company _____ Phone _____

Insurance Co. Address _____

Insured's Employer _____ Phone _____

Insured's SS# _____ Group# _____ Local# _____

If you have double dental insurance coverage, complete this for the second coverage.

Name _____

Insurance Company _____ Phone _____

Insurance Co. Address _____

Insured's Employer _____ Phone _____

Insured's SS# _____ Group# _____ Local# _____

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY	YES	NO
HOW LONG SINCE You Have Seen A Dentist:		
Last COMPLETE Dental Exam, Date:		
Last FULL MOUTH X-RAYS, Date: Bite Wings		
Are you having PROBLEMS now?	☐	☐
WHAT?		
Is your present dental health POOR?	☐	☐
Do you wear DENTURES? (Partials or Full) Are you happy with them?	☐	☐
Would you like to know more about PERMANENT REPLACEMENTS?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAIN?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment:

FEAR of pain # LACK of concern #

COST of treatment # MISSING work time #

CONSENT:
I the undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1.5% finance charge (18% annually) will be added to any balance over 60 days. In the event of default, I (WE) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

MEDICAL HISTORY	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐
For what?		
What MEDICATIONS are you currently taking?		
Are you PREGNANT?	☐	☐
Do you SMOKE?	☐	☐
FAMILY PHYSICIAN _____ PHONE NO. _____		

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

Heart Disease or Attack	AIDS/ARC	Bruise Easily
Angina Pectoris	Hepatitis A (infectious)	Emphysema
High Blood Pressure	Hepatitis B (serum)	Tuberculosis (TB)
Heart Murmur	Liver Disease	Asthma
Rheumatic Fever	Blood Transfusion	Hay Fever
Congenital Heart Lesions	Drug Addiction	Sinus Trouble
Mitral Valve Prolapse	Hemophilia (Bleeding Problems)	Allergies or Hives
Artificial Heart Valve	Fever Blisters	Diabetes
Heart Pacemaker	Epilepsy or Seizures	Thyroid Disease
Heart Surgery	Nervousness	Radiation Treatment
Artificial Joints (Hip, Knee)	Psychiatric Treatment	Arthritis
Anemia	Glaucoma	Cortisone Medicine
Stroke	Chemotherapy (Cancer, Leukemia)	Pain in Jaw Joints
Kidney Trouble	Venereal Disease (Syphilis, Gonorrhea, etc.)	Alcoholism
Ulcers		Cosmetic Surgery

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin	Local Anesthetic	Erythromycin
Nitrous Oxide	Codeine	Penicillin

Are you aware of being allergic to any other medications or substances? _____

2320 Concord Lake Road
Concord, NC 28025

Philip M. Sobo, D.D.S., P.A.
GENERAL AND COSMETIC DENTISTRY

704.786.9100
www.drphilipsobo.com

PATIENT Signature (Parent of Child) _____ Date _____ DENTIST Signature _____