



Steven L. Hatcher, DDS, PA

IMPLANT, COSMETIC, SEDATION & GENERAL DENTISTRY

2707C PINEDALE ROAD ♦ GREENSBORO, NC 27408-2020

REGISTRATION AND HEALTH HISTORY

Name: _____ Social Security #: _____

Name we should call you: _____ Date of Birth: _____

Home Phone #: _____ Cell #: _____ E-mail Address: _____

Address: _____

Employed By: _____

Position: _____ Work Phone# _____

Marital Status: _____ Spouse's Name: _____

Spouse's SS#: _____ Spouse's Date of Birth: _____

Spouse Employed By: _____

Position: _____ Work Phone#: _____

Nearest Relative (In case of emergency): _____

Phone #: _____ City & State: _____

Who may we thank for referring you to our practice? _____

Who will pay your account? _____

Purpose of this visit: _____

INSURANCE INFORMATION:

Name of Primary Dental Insurance Company: _____

Name of Employee/Policy Holder: _____ Group #: _____

Member/Subscriber/Employee # (If Applicable) _____

MEDICAL HISTORY:

Name & phone # of Primary Care Physician: _____

Date of your last complete physical: _____

Are you taking any medication, pills, drugs, vitamins or supplements now? _____ If so, list them below:

Name of Medication/Drug/Supplement:

Purpose/Reason:

- 5) Do you have a burning sensation in your mouth? **YES** or **NO**
- 6) Are you troubled with dryness in your mouth? **YES** or **NO**
- 7) Do you have any pain or soreness around your ears, cheeks, or other parts of your face? **YES** or **NO**
- 8) Do you have chronic headaches? **YES** or **NO**
- 9) Have you ever had periodontal treatment or gum surgery? **YES** or **NO**
If Yes, when? _____ By Whom? _____
- 10) Have you ever been informed of any gum problems? **YES** or **NO**
If Yes, when? _____ By Whom? _____
- 11) Do your gums bleed when you brush your teeth? **YES** or **NO**
- 12) Does food catch between your teeth? **YES** or **NO**
- 13) Do you drink sodas/pop? **YES** or **NO**
- 14) Are you aware of a bad taste or odor in your mouth? **YES** or **NO**
- 15) Please indicate which items you use daily.
- Hard-bristle toothbrush
 - Soft-bristle toothbrush
 - Electric toothbrush
 - Proxi-brush
 - Rubber Tip
 - Dental Floss
 - Water Spray
 - Stimulents or toothpicks
 - Other _____
- 16) Are you aware of any growths or swelling in your mouth? **YES** or **NO**
If Yes, Where are they located and how long have they existed? _____

- 17) Do you have frequent cold sores, canker sores, or fever blisters on your gums, cheeks or lips? **YES** or **NO** If Yes, how often? _____
- 18) Are you aware of your jaw clicking, popping, or making grating-like noises? **YES** or **NO** If Yes, when? _____
- 19) Do your jaw muscles feel tired, stiff or painful? **YES** or **NO**
- 20) Do you chew gum? **YES** or **NO**
- 21) Are you aware of clenching your teeth during the day? **YES** or **NO** If Yes, how often?

- 22) Have you ever been told that you grind your teeth during your sleep? **YES** or **NO** If Yes, how often? _____
- 23) Do you wear a removable denture or appliance? **YES** or **NO** If Yes, when do you wear it? _____
- 24) Are you frustrated by needing constant dental repair because of active dental disease? **YES** or **NO**
- 25) Are you anxious about dental treatment? **YES** or **NO**
- 26) Do you have any disease or known condition which has not been addressed in the above. That you feel is important for us to know? If Yes, please explain: _____

27) My mouth is:

- Very Comfortable.
- Moderately Comfortable.
- Uncomfortable.

28) I:

- Think the appearance of my mouth is excellent.
- Think the appearance of my mouth is adequate.
- Wish I could change the appearance of my mouth.

If so, what would you change? _____

29) I:

- Want to save my teeth at all costs.
- Prefer to keep my teeth if cost and time are reasonable.
- Am not very interested in setting personal goals to achieve optimum oral health.

30) I:

- Have followed the recommendations for optimum dental health given by my dentist.
- Have not done what dentists recommended I do with my mouth.
- Usually only go to the dentist for emergencies.

31) What are some questions about dentistry and your oral health that you have never had adequately answered? _____

As it relates to my medical history, all of the preceding answers are true and correct to the best of my knowledge. If I ever have a change in my health, or if my medications change, I will inform Dr. Hatcher or his staff at my next dental appointment without fail. (Insurance patients only: I authorize release of any information relating to dental insurance claims.) I understand that I am responsible for all costs of dental treatment and that before credit is extended, a credit report will be obtained.

Signature _____ Date _____