Welcome to the office of Dr. Christopher Waters!
2916 W. Stolley Park Suite A.
Grand Island, NE 68801 (308) 382-1734

Today's Date:_____ **We appreciate the confidence you place with us to provide your dental services.**

Patient name: _____ Date of birth: _____ Sex: _____ Age: _____

Home address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ E-mail:_____

Please select appointment reminder preferences (✓all that apply) ☐ Text ☐ Email ☐ Phone – Home ☐ Phone – Work

SS #: _____ Employer/Occupation: _____Business Phone: _____

Whom may we thank for referring you to our office? _____

If patient is 18 years old or younger:
Mother's Information Name: _____ Birthdate: _____
Employer_____ Work Number_____
Father's Information Name: _____Birthdate: _____
Employer _____ Work Number_____
Marital Status: ☐ Married ☐ Separated ☐Divorced ☐Widowed ☐Partnered
Who is responsible for this account? _____
If patient is a full time college student:
School Name_____ Number of Semester Hours_____

If Married
Spouse's name _____Work Number _____Cell Number _____

Emergency contact (other than spouse):_____ Relationship_____ Phone Number_____

Dental Insurance Coverage
Primary dental insurance: _____Employer_____

Secondary dental insurance: _____Employer _____

Subscriber's name: _____ Date of birth: _____ SS #: _____

Dental History

Name of Previous Dentist_____
Date of Last Dental Visit_____
Are you happy with the shape of your teeth? Y N
Are you happy with the color of your teeth? Y N
How often do you brush? _____ floss?_____
Brush is Soft Medium Hard Mechanical
Have you had? Orthodontic Treatment (Braces)
Periodontal Treatment (Gum Disease)
For Children – does the child have any of the following habits?
☐ Thumb/Finger sucking ☐Going to bed with a bottle
☐ Lip Sucking/Biting ☐Nail Biting

Do you have any of the following?
☐ Bleeding Gums ☐ Loose Teeth
☐ Burning Sensation on Lips and Tongue
☐ Clicking or Popping Jaw
☐ Dry Mouth ☐ Gums swollen or tender
☐ Food collection between teeth
☐ Grinding or clenching teeth
☐ Mouth Breathing ☐ Sores or growths in mouth
☐ Sensitivity to Cold Heat Sweets Chewing
(circle any that apply)
☐ Blisters/sores in or around the mouth

Other Side ⇨

Medical History

Original Review _____Dr.'s Initials

It is important to know your medical history. These facts have a direct bearing on your dental health. Thank you for taking the time to completely fill out this registration. **Do you have or have you had any of the following?**

AIDS/HIV Positive	**Yes___No___**	**Glaucoma**	**Yes___No___**	**Sickle Cell Disease**	**Yes___No___**
Alzheimer's Disease	**Yes___No___**	**Hay Fever**	Yes___No___	**Sinus Trouble**	**Yes___No___**
Anaphylaxis	**Yes___No___**	**Heart Attack/ Failure**	**Yes___No___**	**Spina Bifida**	**Yes___No___**
Anemia	**Yes___No___**	**Heart Murmur**	**Yes___No___**	**Stomach Intestinal Disease**	**Yes___No___**
Angina	**Yes___No___**	**Heart Pacemaker**	**Yes___No___**	**Stroke**	**Yes___No___**
Arthritis/Gout	**Yes___No___**	**Heart Trouble Disease**	**Yes___No___**	**Swelling of Limbs**	**Yes___No___**
Artificial Heart Valve	**Yes___No___**	**Hemophilia**	**Yes___No___**	**Thyroid Disease**	**Yes___No___**
Artificial Joint	**Yes___No___**	**Hepatitis A**	**Yes___No___**	**Tonsilitis**	**Yes___No___**
Asthma	**Yes___No___**	**Hepatitis B or C**	**Yes___No___**	**Tuberculosis**	**Yes___No___**
Blood Disease	**Yes___No___**	**Herpes**	**Yes___No___**	**Tumors or Growths**	**Yes___No___**
Blood Transfusion	**Yes___No___**	**High Blood Pressure**	**Yes___No___**	**Ulcers**	**Yes___No___**
Breathing Problem	**Yes___No___**	**High Cholesterol**	**Yes___No___**	**Venereal Disease**	**Yes___No___**
Bruise Easily	**Yes___No___**	**Hives or Rash**	**Yes___No___**	**Yellow Jaundice**	**Yes___No___**
Cancer	**Yes___No___**	**Hypoglycemia**	**Yes___No___**	**Any other disease not listed?**	**Yes___No___**
Chemotherapy	**Yes___No___**	**Irregular Heartbeat**	**Yes___No___**		
Chest Pains	**Yes___No___**	**Kidney Problems**	**Yes___No___**	**Comments**_____	
Cold Sores/Fever Blisters	**Yes___No___**	**Leukemia**	**Yes___No___**	_____	
Congenital Heart Disorder	**Yes___No___**	**Liver Disease**	**Yes___No___**	**Are you under a physician's care? Yes___No___**	
Convulsions	**Yes___No___**	**Low Blood Pressure**	**Yes___No___**	**If Yes, please explain**_____	
Cortisone Medicine	**Yes___No___**	**Lung Disease**	**Yes___No___**		
Diabetes	**Yes___No___**	**Mitral Valve Prolapse**	**Yes___No___**	**Physician's Name:**_____	
Drug Addiction	**Yes___No___**	**Osteoporosis**	**Yes___No___**	**Have you ever been hospitalized or had a major**	
Easily Winded	**Yes___No___**	**Pain in Jaw Joints**	**Yes___No___**	**surgery? Yes___No___**	
Eating Disorder	**Yes___No___**	**Parathyroid Disease**	**Yes___No___**	**If Yes, please explain**_____	
Emphysema	**Yes___No___**	**Psychiatric Care**	**Yes___No___**		
Epilepsy or Seizures	**Yes___No___**	**Radiation Treatments**	**Yes___No___**	**Do you use tobacco? Yes___No___**	
Excessive Bleeding	**Yes___No___**	**Recent Weight Loss**	**Yes___No___**	**If Yes, circle type: Smoke Chew**	
Excessive Thirst	**Yes___No___**	**Renal Dialysis**	**Yes___No___**	**How much?_____ For how many years?_____**	
Fainting Spells / Dizziness	**Yes___No___**	**Rheumatic Fever**	**Yes___No___**	**Women**	
Frequent Cough	**Yes___No___**	**Rheumatism**	**Yes___No___**	**Are you pregnant? Yes___No___**	
Frequent Diarrhea	**Yes___No___**	**Scarlet Fever**	**Yes___No___**	**Are you nursing? Yes___No___**	
Genital Herpes	**Yes___No___**	**Shingles**	**Yes___No___**	**Are you taking birth control pills? Yes___No___**	

MEDICATIONS

Are you now taking?

- ❑ Antibiotics_____
- ❑ Aspirin (Dosage/Day_____mg)
- ❑ Coumadin/Plavix (Blood Thinners)
- ❑ High Blood Pressure Medication_____
- ❑ Insulin or Oral Medication for Diabetes_____
- ❑ Herbal Supplements_____
- ❑ Nitroglycerin

Do you or have you taken?

- ❑ Phen-fen (also known as Redux or Pandimin
- ❑ Medication for Osteoporosis (Biosphosphonates)

List ALL other medication you take:

_____

_____

ALLERGIES

Are you allergic to any of the following?

- ❑ Aspirin
- ❑ Penicillin
- ❑ Codeine
- ❑ Local Anesthetics
- ❑ Acrylic
- ❑ Nickel and other metals
- ❑ Latex
- ❑ Sulfa

List any other allergies:

_____

_____

_____

_____

Authorization Signature

I understand that the information I have given today is correct to the best of my knowledge, I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____ _____

Signature of Patient or Patient's Representative **Date**

_____

(Relationship to Patient if not signed by the Patient)