Patient Registration

First Name:_____ Last Name:_____ MI:____

Patient is: □ Policy Holder Preferred Name:_____

□ Responsible Party

Patient Information

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work:_____ Cell:_____

Sex: □ Male □ Female Marital Status: □ Married □ Single □ Divorced

Birth Date:_____ Age:_____ Social Sec:_____

Drivers License:_____ Email:_____

I would like to receive correspondences via e-mail: □ yes □ no

Employment status: □ Full time □ Part time □ Retired

Student Status: □ Full time □ Part time

Referred By: □ TV □ Radio □ Patient:_____

Previous Dentist:_____ Last time to a dentist:_____

Emergency Contact:_____ Emergency Contact Phone #_____

Responsible Party (if someone other than the patient)

First Name:_____ Last Name:_____ MI:____

Address:_____ City/State/Zip:_____

Home Phone:_____ Cell:_____ Work:_____

Birth date:_____ Soc Sec:_____ Drivers Lic:_____

Primary Insurance Information

Policy Holder:_____

Relationship to Patient: □ Self □ Spouse □ Child □ Other

Policy Holders Soc. Sec:_____ Date of Birth:_____

Policy Holders ID #_____ Patients ID#_____

Employer:_____ Ins. Company:_____

Secondary Insurance Information

Policy Holder:_____

Relationship to Patient: □ Self □ Spouse □ Child □ Other

Policy Holders Soc. Sec:_____ Date of Birth:_____

Policy Holders ID #_____ Patients ID#_____

Employer:_____ Ins. Company:_____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Healthy problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? □ Yes □ No

If yes, please explain:_____

Have you ever been hospitalized or had a major operation? □ Yes □ No

If yes, Please explain:_____

Have you ever had a serious head or neck injury? □ Yes □ No

If yes, Please explain:_____

Are you taking any medications, pills, or drugs? □ Yes □ No

If yes, Please explain:_____

_____

Do you take, or have you taken, Phen-Fen or Redux? □ Yes □ No

Are you on a special Diet? □ Yes □ No

Do you use tobacco? □ Yes □ No

Do you use any controlled Substances? □ Yes □ No

Pregnant/Trying to get pregnant? □ Yes □ No

Taking Oral Contraceptives? □ Yes □ No Nursing? □ Yes □ No

Are you allergic to any of the following?

□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Local Anesthetics □ Other:_____

Do you have or have you had, any of the following?

AIDS/HIV	□ Yes □ No	Emphysema	□ Yes □ No
Alzheimer's Disease	□ Yes □ No	Epilepsy/Seizures	□ Yes □ No
Anaphylaxis	□ Yes □ No	Excessive Bleeding	□ Yes □ No
Anemia	□ Yes □ No	Excessive Thirst	□ Yes □ No
Angina	□ Yes □ No	Fainting Spells/Dizziness	□ Yes □ No
Arthritis/Gout	□ Yes □ No	Frequent Cough	□ Yes □ No
Artificial Heart Valve	□ Yes □ No	Frequent Diarrhea	□ Yes □ No
Artificial Joint	□ Yes □ No	Frequent Headaches	□ Yes □ No
Asthma	□ Yes □ No	Genital Herpes	□ Yes □ No
Blood Disease	□ Yes □ No	Glaucoma	□ Yes □ No
Blood Transfusion	□ Yes □ No	Hay Fever	□ Yes □ No
Breathing Problem	□ Yes □ No	Heart Trouble/Disease	□ Yes □ No
Bruise Easily	□ Yes □ No	Hemophilia	□ Yes □ No
Cancer	□ Yes □ No	Hepatitis A	□ Yes □ No
Chemotherapy	□ Yes □ No	Hepatitis B or C	□ Yes □ No
Chest Pains	□ Yes □ No	Herpes	□ Yes □ No
Cold Sores/Fever Blisters	□ Yes □ No	High Blood Pressure	□ Yes □ No
Congenital Heart Disease	□ Yes □ No	Hives or Rash	□ Yes □ No
Convulsions	□ Yes □ No	Hypoglycemia	□ Yes □ No
Cortisone Medicine	□ Yes □ No	Irregular Heartbeat	□ Yes □ No
Diabetes	□ Yes □ No	Kidney Problems	□ Yes □ No
Drug Addiction	□ Yes □ No	Leukemia	□ Yes □ No
Easily Winded	□ Yes □ No	Liver Disease	□ Yes □ No

Medical History continued….

Low Blood Pressure	□ Yes □ No	Sickle Cell Disease	□ Yes □ No
Lung Disease	□ Yes □ No	Sinus Trouble	□ Yes □ No
Mitral Valve Prolapse	□ Yes □ No	Spina Bifida	□ Yes □ No
Osteoporosis	□ Yes □ No	Stomach/Intestinal Disease	□ Yes □ No
Pain in Jaw Joints	□ Yes □ No	Stroke	□ Yes □ No
Parathyroid Disease	□ Yes □ No	Swelling of Limbs	□ Yes □ No
Psychiatric Care	□ Yes □ No	Thyroid Disease	□ Yes □ No
Radiation Treatment	□ Yes □ No	Tonsillitis	□ Yes □ No
Recent Weight Loss	□ Yes □ No	Tuberculosis	□ Yes □ No
Renal Dialysis	□ Yes □ No	Tumors or Growths	□ Yes □ No
Rheumatic Fever	□ Yes □ No	Ulcers	□ Yes □ No
Rheumatism	□ Yes □ No	Venereal Disease	□ Yes □ No
Scarlet Fever	□ Yes □ No	Yellow Jaundice	□ Yes □ No
Shingles	□ Yes □ No		

Have you ever had any serious Illness not listed above? □ Yes □ No

If yes, please explain:_____

Comments:_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, or Responsible Party:_____ Date:_____