PATIENT REGISTRATION & MEDICAL HISTORY

Patient:_____ Phone:_____
Last Name First Name Initial Preferred Name

Street Address: _____ City_____ State _____ Zip_____

Sex ❑ Male ❑ Female Birthdate:_____ ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Employed By:_____ Occupation: _____

Business Address:_____ Business Phone: _____

Social Security #:_____ Who is responsible for account: _____

Spouse Name:_____ Spouse Employer: _____ Spouse DOB_____

Name of Dental Insurance Company_____ Group Number:_____

Name of Primary Insured: _____

In case of emergency notify: _____ Phone: _____

Whom may we thank for referring you?: _____

DENTAL HISTORY

Why have you come to the dentist today? _____

Date of last dental treatment:_____

Have you ever responded adversely to dental treatment? ❑ Yes ❑ No

Please explain: _____

Do you grind your teeth? _____

MEDICAL HISTORY

Physician's Name: _____

Are you under care of a physician now? ❑ Yes ❑ No Condition: _____

(Women) Are you pregnant/nursing? ❑ Yes ❑ No Due Date:_____

Have you ever had a blood transfusion?: ❑ Yes ❑ No Date: _____

Are you on a bisphosphonate (i.e. Fosamax, Actonel, Boniva, or Reclast) or have you been in the last 3 years? _____

(✔) Check if you have ever had any of the following:

- ❑ AIDS/HIV
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problem (describe)

_____

- ❑ Hepatitis
- ❑ Hemophilia
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Psychiatric Care
- ❑ Radiation Treatments
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Sinus Problem
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tobacco Habit
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Venereal Disease

MEDICATIONS

List any medications you are taking: _____

_____

_____

Pharmacy Name:_____

ALLERGIES

❑ Penicillin ❑ Aspirin

❑ Sulfa ❑ Dental Anesthetics

❑ Other - Please List: _____

_____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my Dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____ Signature _____