PATIENT REGISTRATION

Last Name: _____ First Name: _____ Preferred Name: _____

Address: _____
Street City, State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

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

Birth date: _____ Social Security #: _____

Employment Status: □ Full Time □ Part Time □ Self Employed □ Retired □ Unemployed Student Status: □ FT □ PT

Employer: _____ Occupation: _____ Referred By: _____

Responsible Party (if different from patient)

Last Name: _____ First Name: _____ Relationship to Patient: _____

Address: _____
Street City, State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Social Security: _____ Driver's Lic #: _____

Primary Insurance Information:

Name of Insured: _____ Relationship to Insured: □ Self □ Spouse □ Child □ Other

Employer ID: _____ Carrier ID: _____

Insured Social Security #: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Secondary Insurance Information:

Name of Insured: _____ Relationship to Insured: □ Self □ Spouse □ Child □ Other

Employer ID: _____ Carrier ID: _____

Insured Social Security #: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

(over)
Revised November 2011

Medical History

Patient Name: _____ Birth Date: _____

Although Dental Personnel primarily treat the area in and around your mouth is part of your entire body. Heath problems that you may have, or medication 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 list:

_____

_____

Do you need to pre-medicate for heart or joint replacements? Yes No If yes, please explain: _____
Do you take, or have you taken Boniva or Fosamax? Yes No
Do you use tobacco? Yes No

Women: Are you pregnant/Trying to get pregnant? □ Yes □ No Taking oral contraceptives? □ Yes □ No Nursing: □ Yes □ No

Are you allergic to any of the following?
□ Penicillin □ Aspirin □ Codeine □ Erythromycin □ Latex □ Acrylic □ Local Anesthetic
Please list any other drugs that you are allergic to: _____

Why have you come to the dentist today? _____ Are you currently in pain? □ Yes □ No
Date of your last dental treatment ____/____/____ Last cleaning ____/____/____
Do you experience stress or anxiety when you visit a dental office? □ Yes □ No
Have you ever had a serious or difficult problem associated with any previous dental treatment? □ Yes □ No
Have you ever been treated for gum disease? □ Yes □ No Do your gums bleed now? □ Yes □ No
Do you now or have you ever experienced any pain or discomfort in your jaw joint (TMJ)? □ Yes □ No

Do you now have or have you ever had any of the following?

AIDS or HIV +	Yes No	Drug/Alcohol Addiction	Yes No	Liver Disease	Yes No
Alzheimer's disease	Yes No	Emphysema	Yes No	Low Blood Pressure	Yes No
Allergies/Hay Fever	Yes No	Epilepsy or Seizures	Yes No	Lung Disease	Yes No
Anemia	Yes No	Excessive Bleeding	Yes No	Migraines/Frequent Headache	Yes No
Anorexia, Bulimia or Acid Reflex	Yes No	Fainting Spells/Dizziness	Yes No	Mitral Valve Prolapse	Yes No
Arthritis/Rheumatoid/Gout	Yes No	Frequent Cough	Yes No	Osteoporosis	Yes No
Artificial Bones or Joints	Yes No	Glaucoma	Yes No	Pain in Jaw Joints	Yes No
Artificial Heart Valves	Yes No	Heart Attack/Failure	Yes No	Psychiatric Care	Yes No
Asthma	Yes No	Heart Murmur	Yes No	Rheumatic Fever	Yes No
Blood Disease	Yes No	Heart Pace Maker	Yes No	Rheumatism	Yes No
Blood Transfusion	Yes No	Heart Trouble/Disease	Yes No	Shingles	Yes No
Cancer/Chemotherapy/Radiation	Yes No	Hepatitis A, B or C	Yes No	Sinus Trouble	Yes No
Celiac Disease	Yes No	Herpes (oral/genital)	Yes No	Stroke	Yes No
Cold Sores/Fever Blisters	Yes No	High Blood Pressure	Yes No	Thyroid Disease	Yes No
Congenital Heart Defect	Yes No	HPV	Yes No	Tonsillitis	Yes No
Convulsions/Seizures	Yes No	Kidney Problems	Yes No	Tuberculosis	Yes No
Diabetes	Yes No	Leukemia	Yes No	Ulcers	Yes No
				Venereal Disease	Yes No

Have you ever had any serious illness not listed above?

_____

_____

Comments/Concerns:_____

_____

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian _____ Date _____
In Case of Emergency, contact _____ Phone _____