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 □ I	Divorced 🗆 Separa	ated 🗆 Widowed
Birth date:	Social Security	#:	-	
Employment Status: □ Full Time □ Part	Time □ Self Emp	ployed 🗆 Retired 🗆 Uner	nployed	Student Status: □ FT □ PT
Employer:	Occupation:		Referred By:	
Responsible Party (if different from pati	ent)			
Last Name:	First Name:		Relationship to 2	Patient:
Address:Street		City, State		Zip Code
Home Phone:	Work Phone:		Cell Phone:	
Birth Date:				
Primary Insurance Information:	,			
Name of Insured:		Relationship to Insured:	□ Self □ Spouse	□ Child □ Other
Employer ID:		-	-	
Insured Social Security #:				
Employer:				
Address:		Address:		
City, State, Zip:		City, State, Zip:		
Secondary Insurance Information	1:			
Name of Insured:		Relationship to Insured:	□ Self □ Spouse	□ Child □ Other
Employer ID:		Carrier ID:		
Insured Social Security #:		Insured Birth Date:		
Employer:				
Address:		Address:		
City, State, Zip:		City, State, Zip:		

Medical History

Although Dental Personnel primarily treat the area in and around your mouth is part of your entire body. Headh problems that you may hav or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answerit the following questions. Are you under a physician's care now? Yes No If yes, please explain: Have you ever heen hospitalized or had a major operation? Yes No If yes, please explain: Have you ever head 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: Are you taking any medications, pills or drugs? Yes No If yes, please explain: Do you take, or have you taken Boniva or Fosamax? Yes No O you sue tobacco? Yes No Women: Are you taken Boniva or Fosamax? Yes No Are you currently in pain? Yes No Women: Are you currently in got get pregnant? Yes No Are you currently in pain? Yes No Are you	Patient Name:			Birth Date: _		
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 nece to pre-medicate for heart or joint replacements? Yes No If yes, please explain: Do you take. Do you set tobacco? Yes No Taking oral contraceptives? Yes No Momen: Are you argenant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing: Yes No Are you allergic to any of the following?	or medication that you may be taking					
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 use tobacco? Yes No Taking oral contraceptives? Yes No Women: Are you altergic to any of the following? Yes No Taking oral contraceptives? Yes No Pencifilin Aspirin Codeine Erythromycin Latex Aerylic Local Anesthetic Please list any other drugs that you are allergic to:	Are you under a physician's care now?		Yes No If ye	es, please expl	ain:	
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 use tobacco? Yes No Types No Women: Are you gregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Mremen: Are you allergic to any of the following? Benefilin Codeine Erythromycin Latex Acrylic Local Anesthetic Please list any other drugs that you are allergic to:	Have you ever been hospitalized or	r had a major ope	eration? Yes No If yes	s, please explai	n:	
Do you need to pre-medicate for heart or joint replacements? Yes No If yes, please explain:	Have you ever had a serious head of	or neck injury?	Yes No If yes	s, please explai	in:	
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?	Are you taking any medications, pi	lls or drugs?	Yes No If yes	s, please list:		
Are you allergic to any of the following? Penicillin \sprin Codeine Erythromycin Latex Acrylic Local Anesthetic Please list any other drugs that you are allergic to:	Do you take, or have you taken Bo		? Yes No	s, please explai	n:	
Penicillin Aspirin Codeine Erythromycin Latex Acrylic Local Anesthetic Please list any other drugs that you are allergic to:	Women: Are you pregnant/Trying	to get pregnant?	□ Yes □ No Taking o	ral contracepti	ves? 🗆 Yes 🗆 No 🛛 Nursin	g: 🗆 Yes 🗆 No
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 □ Yes □ No Do you now or have you ever experienced any of the following? □ Yes □ No □ Yes □ No Do you now have or have you ever had any of the following? □ Yes □ No □ Yes No AlDS or HIV + Yes No Do you of Second Times Ves No Low Blood Pressure Yes No Allergies/Hay Fever Yes No Excessive Bleeding Yes No Low Blood Pressure Yes No Anemia Yes No Excessive Bleeding Yes No Migraines/Frequent Headache Yes No Arthritis/Rheumatoid/Gout Yes No Fainting Spells/Dizzines Yes No Painting Spells/Dizzines Yes No Arthritis/Rheumatoid/Gout Yes No Arthritis/Rheumatoid/Gout Yes No Heart Attack/Failure Yes No Painting Spells/D	□ Penicillin □ Aspirin	□ Codeine				al Anesthetic
AIDS or HIV +YesNoDrug/Alcohol AddictionYesNoLiver DiseaseYesNoAlzheimer's diseaseYesNoEmphysemaYesNoLow Blood PressureYesNoAllergies/Hay FeverYesNoEpilepsy or SeizuresYesNoLung DiseaseYesNoAnemiaYesNoExcessive BleedingYesNoMigraines/Frequent HeadacheYesNoAnorexia, Bulimia or Acid ReflexYesNoFrequent CoughYesNoMitral Valve ProlapseYesNoArthritis/Rheumatoid/GoutYesNoFrequent CoughYesNoOsteoporosisYesNoArtificial Bones or JointsYesNoGlaucomaYesNoPain in Jaw JointsYesNoAsthmaYesNoHeart Attack/FailureYesNoPsychiatric CareYesNoBlood DiseaseYesNoHeart MurmurYesNoRheumatismYesNoBlood TransfusionYesNoHeart Trouble/DiseaseYesNoStinus TroubleYesNoCancer/Chemotherapy/RadiationYesNoHerpes (oral/genital)YesNoStrokeYesNoCold Sores/Fever BlistersYesNoHigh Blood PressureYesNoThyroid DiseaseYesNoConvulsions/SeizuresYesNoHigh Blood PressureYesNoThyroid DiseaseYesNoC	Do you experience stress or anxiety Have you ever had a serious or diff Have you ever been treated for gun Do you now or have you ever expe	y when you visit ficult problem as n disease?	a dental office? sociated with any previous of es Do your or discomfort in your jaw j	lental treatmer gums bleed no	□ Yes □ No nt? □ Yes □ No w? □ Yes □ No	Yes 🗆 No
Trave you ever had any serious inness not instea above:	AIDS or HIV + Alzheimer's disease Allergies/Hay Fever Anemia Anorexia, Bulimia or Acid Reflex Arthritis/Rheumatoid/Gout Artificial Bones or Joints Artificial Heart Valves Asthma Blood Disease Blood Transfusion Cancer/Chemotherapy/Radiation Celiac Disease Cold Sores/Fever Blisters Congenital Heart Defect Convulsions/Seizures Diabetes	Yes No Yes No	Drug/Alcohol Addiction Emphysema Epilepsy or Seizures Excessive Bleeding Fainting Spells/Dizziness Frequent Cough Glaucoma Heart Attack/Failure Heart Murmur Heart Murmur Heart Pace Maker Heart Trouble/Disease Hepatitis A, B or C Herpes (oral/genital) High Blood Pressure HPV Kidney Problems Leukemia	Yes No Yes No	Low Blood Pressure Lung Disease Migraines/Frequent Headache Mitral Valve Prolapse Osteoporosis Pain in Jaw Joints Psychiatric Care Rheumatic Fever Rheumatism Shingles Sinus Trouble Stroke Thyroid Disease Tonsillitis Tuberculosis Ulcers	Yes No Yes No

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