

PATIENT REGISTRATION AND MEDICAL HISTORY

(PLEASE PRINT)

Date _____ E-mail _____
Cell Phone _____ Home Phone _____

Patient _____
Last Name First Name Initial Preferred Name

Street Address _____ City _____ State _____ Zip _____

Sex: M F Age _____ Birthdate _____
 Single Married Widowed Separated Divorced

Social Security # _____

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Spouse Name _____ Spouse Birthdate _____

Spouse's Social Security # _____

Spouse Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Who is responsible for this account? _____ Relationship to Patient _____

Name of Dental Insurance Company _____ Group Number _____

In case of emergency, who should be notified? _____ Phone _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____

Have you ever had any of the following? (check boxes that apply):

YES	NO		YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet
<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, Jaundice or Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Neck Glands
<input type="checkbox"/>	<input type="checkbox"/>	Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Nervous Problems	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	"A.I.D.S." or Other Immunosuppressive Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valves or Joints	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Medicine or Drugs	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	General Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Chemical Dependency
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Latex Allergy
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Nickel or Metal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/>	Phen Phen or Redux Medicine	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse			

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____ If so, what _____

Have you ever responded adversely to medical or dental treatment? _____

Are you taking any medication at this time? _____ If so, what _____

Are you under the care of a physician? Yes No

For what conditions? _____

(Women) Do you suspect that you are pregnant? Yes No Are you nursing? Yes No Are you taking birth control pills? Yes No

Is there anything else we should know about your medical history? _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____