

PATIENT REGISTRATION AND MEDICAL HISTORY

DATE: _____

PATIENT: _____
Last Name First Name Initial Preferred Name

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

What is the best daytime phone # to reach you? _____

Mailing Address _____ City _____ State _____ Zip _____

Permanent Address _____ City _____ State _____ Zip _____

Sex: M F Age _____ Birth Date _____ Single Married Widowed Divorced Separated

Employed by _____ SSN# _____

Student Yes No Name of School _____ City _____ State _____

Spouse Name _____

Spouse Employed By _____ Business Phone _____

Insurance Company _____ Subscriber's Name/DOB _____

Subscriber's SSN _____ Subscriber's Place of Employment _____

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

How did you hear about our office? _____

MEDICAL HISTORY

Physician's Name & Phone _____ Date of Last Physical _____

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Special Diet |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Headaches | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Infective Endocarditis | <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> "A.I.D.S." or Other | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Immunosuppressive Disorders | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Chronic Diarrhea |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Allergies to Anesthetics |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Allergies to Medicine or Drugs |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> General Allergies |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Respiratory Disease | |

In the past, have you been required to take antibiotics prior to dental treatment for a reason other than infection? _____

If so, for what condition? _____

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

If so, for what conditions? _____

If patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? Yes No Are you nursing? Yes No

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

I give my permission to the doctor and staff to submit any pictures or x-rays which would help facilitate payment on any claims to my insurance company or to any specialist.

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.

Signature _____ Date _____