

PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ (PLEASE PRINT) 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

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

Spouse/Parent Employed by _____ Occupation _____

Business Address _____ Business Phone _____

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

Social Security # _____ Spouse/Parent Social Security # _____

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):

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease | <input type="checkbox"/> "A.I.D.S." or Other |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Immunosuppressive Disorders |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Allergies to Anesthetics | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Allergies to Medicine or Drugs | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> Artificial Heart Valves or Joints | <input type="checkbox"/> General Allergies | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Have you ever been tested for AIDS? |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Arthritis | Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Special Diet | <input type="checkbox"/> Have you ever used phen-fen? |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Swollen Neck Glands | <input type="checkbox"/> Do you have a latex allergy? |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Recent Surgery |

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

Are you happy with the appearance of your teeth? _____ If not, please explain on the reverse side.

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? _____

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? _____

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 _____