

PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ Home Phone _____ Cell Phone _____

Patient _____

Street Address _____ City _____ State _____ Zip _____

Sex: ___ Male ___ Female Age _____ Date of Birth _____ ___ Single ___ Married ___ Widowed ___ Sep./Divorced

Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Spouse Name: _____ Spouse employed by: _____

Spouse Occupation _____ Spouse Business Address and Phone _____

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

Patient's Social Security # _____ Spouse/Parent's Social Security # _____

Name of Dental Insurance Company _____ ID # _____ Group # _____

In Case of Emergency who should be notified? _____ Phone # _____

Whom shall we thank for referring you to our office? _____

MEDICAL HISTORY

Physician's Name and Phone # _____ Date of Last Physical _____

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

- Heart Problems, High Blood Pressure, Low Blood Pressure, Circulatory Problems, Nervous Problems, Radiation Treatment, Artificial Heart Valves or Joints, Recent weight loss or gain, Back Problems, Diabetes, Respiratory Disease, Epilepsy, Headaches, Hepatitis A, B, or C, Jaundice, or Liver Disease, Cancer, Psychiatric Care, Chronic Diarrhea, Allergies to Anesthesia, Allergies to Medicine or Drugs, General Allergies, Blood Disease, Arthritis, Special Diet, Swollen Neck Glands, Rheumatic Fever, Sinus Problems, AIDS, HIV or other Immune Disorders, Stroke, Ulcer, Venereal Disease (STD), Chemical Dependency, Hemophilia

Do you have any Drug Allergies or have ever had an adverse reaction to any medication? _____ If so, What? _____

Have you ever responded adversely to medical or Dental treatment? _____ If so, What? _____

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

Are you under the care of a Physician? _____ For what conditions? _____

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

(Women) Do you suspect that you are pregnant? _____ Are you Nursing? _____

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 insurance benefits for which I am entitled. My information will be kept private, except for those purposes listed above. 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 _____