

PATIENT REGISTRATION AND MEDICAL HISTORY

(PLEASE PRINT)

PATIENT INFORMATION

Date _____

Last Name _____ First Name _____ Middle Initial _____ Preferred Name _____
Street Address _____ City _____ State _____ Zip Code _____
Home Phone _____ Cell Phone _____ Email _____
Sex: Male Female Age _____ Birthdate ___/___/___ Single Married Widowed Separated Divorced
Spouse or Parent/Guardian's Name _____
In case of emergency, who should be notified? _____ Phone _____
Whom may we thank for referring you? _____

RESPONSIBLE PARTY:

Name _____ Phone _____ Relationship to Patient _____
Address _____ Birthdate ___/___/___ Social Security Number _____
Employer _____ Occupation _____
Business Address _____ Business Phone _____

INSURANCE INFORMATION:

Insured's Name _____ Birthdate ___/___/___ Insured's Employer _____
Dental Insurance Company _____ Group Number _____
Insurance Company Address _____ ID # _____

SECONDARY INSURANCE INFORMATION:

Insured's Name _____ Birthdate ___/___/___ Insured's Employer _____
Dental Insurance Company _____ Group Number _____
Insurance Company Address _____ ID # _____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Physician's Name _____ Date of last physical _____

Do you have, or have you had, any of the following? _____

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Circulatory Problem | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Pacemaker* | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Herpes | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Respiratory Diseases | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Rheumatic Fever* | |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rheumatism | |

* Condition may require medication N/A Not answered by patient

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? _____

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

(For Woman) Do you suspect you are currently 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.

Signature (Patient or Parent/Guardian) _____

Today's Date _____