PATIENT REGISTRATION

First Name _____ Last Name _____ Middle Init ____
Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Cell Phone _____ Text: Y N
Work Phone _____ Ext _____
Birth Date _____ Sex ____ Social Security Number _____
E-Mail address _____
Marital Status: ____Married ____ Single ____ Divorced ____ Widowed ____ Separated
Name of Spouse _____ Contact Number _____

Employment: _____ Full Time _____ Part Time _____ Retired
Student: _____ Full time _____ Part Time

Primary Insurance Information:
Name of Insured _____ Group # _____
Insured SS/ID# _____ Insured Birth Date _____
Employer _____ Insurance Company _____

Secondary Insurance Information:
Name of Insured _____ Group # _____
Insured SS/ID# _____ Insured Birth Date _____
Employer _____ Insurance Company _____

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.

Are you under the care of a physician now? Yes/No Explain_____
Have you had any serious illness or operation? Yes/No Explain_____
Are you taking any medications or vitamins? Yes/No, Please list in the space provided on page 3
Are you on a special diet? ___ Yes ___ No
Do you use any tobacco products? _____ Yes ____ No
Do you use any controlled substances? ___ Yes ___ No

Women: Are you pregnant? __ Yes __ No/ Taking birth control? __ Yes __ No/ Nursing? ____

Name of physician or specialist: _____

Phone Number: _____

Are you allergic to any of the following?

____ Aspirin	_____ Penicillin	_____Codeine
____ Local Anesthetics	_____ Latex	_____ Sulfa drugs
____Metal	_____ Acrylic	_____ Other _____

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

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

Have you ever had any serious illness that was not listed? __Yes __No Please explain:

_____

_____

Please list all of the medications and vitamins that you are taking and what they are for.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Dental Information

Are you currently in pain? __Yes __No _____

Your current dental health is: ___Good ___Fair ___Poor

Do you like your smile? __Yes __No

Do your gums ever bleed? __Yes __No

How many times a day do you brush? _____

How many times a week do you use dental floss/interdental brushes/toothpicks? _____

Referred by: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient/parent/guardian _____ Date _____

Signature of dentist _____ Date _____

This side is for further information or updates.