PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ (PLEASE PRINT)

Home Phone _____ Cell Phone _____ Email _____

Patient _____
LAST NAME FIRST NAME INITIAL PREFERRED NAME

Home Address _____ City _____ State_____ Zip_____

Sex: ❑ M ❑ F Age: _____ Birthdate: _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Employed by _____ Occupation _____ Yrs. W/Firm _____

Business Address _____ Business Phone _____ Ext. _____

Spouse Name _____

Spouse Employed by _____ Occupation _____

Business Address _____ Business Phone _____

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

Social Security # _____ Spouse's Social Security # _____

Name of Dental Insurance Company _____ Group Number _____

Whom may we thank for referring you? _____

Purpose of Call _____

MEDICAL HISTORY

The name and address of my physician(s) is _____

_____

_____

Have you ever had any of the following? Please answer all questions.

___Yes ___No	Heart Problems	___Yes ___No	Epilepsy	___Yes ___No	Cold Sores or Fever Blisters
___Yes ___No	High Blood Pressure	___Yes ___No	Headaches	___Yes ___No	Fainting or Dizzy Spells
___Yes ___No	Pacemaker	___Yes ___No	Hepatitis, Jaundice or Liver Disease	___Yes ___No	Rheumatic Fever
___Yes ___No	Circulatory Problems	___Yes ___No	Cancer	___Yes ___No	Sinus Problems
___Yes ___No	Nervous Problems	___Yes ___No	Psychiatric Care	___Yes ___No	"A.I.D.S." or other
___Yes ___No	Radiation Treatment	___Yes ___No	Asthma, Bronchitis or Emphysema	___Yes ___No	Immunosuppressive Disorders
___Yes ___No	Artificial Heart Valves or Joints	___Yes ___No	Glaucoma	___Yes ___No	Stroke
___Yes ___No	Thyroid Disease	___Yes ___No	Sleep Apnea or Other Sleep Disorder	___Yes ___No	Ulcer
___Yes ___No	Back Problems	___Yes ___No	General Allergies	___Yes ___No	Sexually Transmitted Diseases
___Yes ___No	Diabetes	___Yes ___No	Pain in the Jaw Joint (TMJ)	___Yes ___No	Chemical Dependence
___Yes ___No	Mitral Valve Prolapse	___Yes ___No	Arthritis	___Yes ___No	Hemophilia or Other Bleeding Problems
				___Yes ___No	Treatment for Osteoporosis

Do you smoke? ❑ Yes ❑ No Packs/Day _____

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

_____

Have you ever responded adversely to medical or dental treatment? ❑ Yes ❑ No

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

_____

Are you under the care of a physician? ❑ Yes ❑ No

For what conditions: _____

Are you happy with your smile? _____ Do you grind your teeth at night? _____

(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 _____

WE ACCEPT CASH OR CHECK *(PAYABLE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE)*