

PATIENT REGISTRATION AND MEDICAL HISTORY

Describe the Reason for Today's Visit _____ Exam Emergency Consult
 Last Full Exam with X-Rays _____ Home Phone _____ Cell/Beeper _____ Business _____

Patient _____
 Last Name First Name Initial Preferred SS#

Street Address _____ City _____ State _____ Zip _____

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

RESPONSIBLE PARTY WILL COMPLETE BELOW • Relationship to Patient _____

Name _____
 Last Name First Name Initial Preferred SS#

Occupation _____ Employed By _____

Business Address _____ Business Phone _____

Name of Dental Insurance Company _____ Group # _____ Ins. Phone # _____

Spouse Name _____
 Last Name First Name Initial Preferred SS#

Spouse Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Name of Dental Insurance Company _____ Group # _____ Ins. Phone # _____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? (NOT LIVING WITH YOU) _____ Phone _____

Whom may we thank for referring you? _____

Who is responsible for this account? _____
 Relationship Phone

MEDICAL HISTORY

Physician's Name _____ Phone # _____ Date of Last Visit _____

Have you had any serious illnesses or operations? _____ If yes, describe _____

Do you have any current Health Problems Yes No If yes, explain _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

(Women) Do you suspect you are pregnant? No Yes Due Date _____ Nursing? Yes No Taking birth control pills? Yes No

Check (✓) if you have or have had any of the following:

IF YES TO ANY OF THE (*)'D CONDITIONS, PLEASE CALL PRIOR TO YOUR APPOINTMENT... PREMEDICATION MAY BE REQUIRED.

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS / HIV or Other | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Immunosuppressive Disorders | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valves * | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Artificial Joints * | <input type="checkbox"/> Fainting | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse * | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur * | <input type="checkbox"/> Pacemaker * | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problems * | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chemical Dependency | Describe _____ | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever * | <input type="checkbox"/> NONE |

MEDICATIONS

Is pre-medication required Yes No
 List medications you are currently taking & correlating diagnosis:

 Pharmacy Name _____
 Phone _____

ALLERGIES

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Sulfas |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> NONE |

SIGNATURE

The above information is accurate and complete to the best of my knowledge. 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 _____