PATIENT REGISTRATION

Today's Date _____ E-mail _____ Work Phone _____
Home Phone _____
Patient's Name _____ Birthdate ___/___/___ ☐ Male ☐ Single
SS# _____ ☐ Female ☐ Married
Address _____ City _____ State _____ Zip _____ Employer _____ Position _____
Person responsible for account, if different from above _____
Who may we thank for referring you to our office? _____

Name of Person with Primary Insurance _____ SS# _____
Employer _____ Birthdate _____
Insurance Co _____ Policy Number _____
Address _____ City _____ State _____ Zip _____ Phone _____

Name of Person with Secondary Insurance _____ SS# _____
Employer _____ Birthdate _____
Insurance Co _____ Policy Number _____
Address _____ City _____ State _____ Zip _____ Phone _____

Spouse's Name _____ Children's Names _____
Name of Nearest Friend or Relative Not Living with You _____ Relationship _____
Address _____ City _____ State _____ Zip _____ Phone _____
Previous Dentist _____
Address _____ City _____ State _____ Zip _____ Phone _____

MEDICAL HISTORY (Please circle the appropriate answer)

DO YOU HAVE OR HAVE YOU EVER HAD:

Hospitalization for illness or surgery..... Yes No
for: _____
An allergic reaction..... Yes No
to: _____
Hives, skin rash, hay fever..... Yes No
Any reaction to:
Aspirin..... Yes No
Penicillin or any antibiotics..... Yes No
Codeine or other narcotics..... Yes No
Dental anesthetic..... Yes No
Any other medication:..... Yes No
(specify):_____

Blood transfusion..... Yes No
Arthritis..... Yes No
Prosthetic joint..... Yes No

Prolonged bleeding..... Yes No
Thyroid / Parathyroid disorders..... Yes No
Herpes..... Yes No
Kidney disease..... Yes No
Hepatitis..... Yes No
Alcoholism / Drug addiction..... Yes No
Diabetes..... Yes No
Epilepsy or seizures..... Yes No
Tuberculosis..... Yes No
Asthma..... Yes No
Emphysema..... Yes No
Sinus trouble..... Yes No
Shortness of breath..... Yes No
Rheumatic fever..... Yes No
Jaundice..... Yes No
Gastric / Stomach disease..... Yes No
Venereal disease..... Yes No
AIDS / ARC..... Yes No

Anemia..... Yes No
Heart murmur..... Yes No
Prosthetic valve..... Yes No
Heart trouble..... Yes No
Arteriosclerosis..... Yes No
High blood pressure..... Yes No
Excessive swollen ankles..... Yes No
Stroke..... Yes No
Chest pains..... Yes No
Tumor or abnormal growth..... Yes No
Radiation treatment..... Yes No
Emotional problems / tension..... Yes No
Lung disease..... Yes No
Sickle Cell disease..... Yes No
Persistent cough..... Yes No
Cancer..... Yes No
Bronchitis..... Yes No
Glomerulonephritis..... Yes No

ARE YOU:

Presently being treated for any illness? Yes No
Aware of a change in your general health in the past year? Yes No
Smoking Yes No How much _____ How long _____
Using smokeless tobacco Yes No
Taking any medication regularly now or within the past year? Yes No _____
If female, are you pregnant? Yes No
If female, are you taking oral contraceptives or hormonal therapy? Yes No

Anything else the Dentist should know? _____

Physician's Name _____
Address _____ City _____ State _____ Zip _____ Phone _____

Your Signature _____ Date _____

FOR OFFICE USE ONLY BELOW

DATE	COMMENTS

REVIEWED BY _____ DATE _____