Patient Registration

Today's Date:___/___/___

Title: □ Mr. □ Mrs. □ Ms. □ Dr.

First Name:_____Middle Initial:_____Last Name:_____

Street:_____City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Date of Birth: ____/____/____ Gender: □ Male □ Female Social Security#:_____

Name of Physician: _____ Phone: _____

Name of General Dentist: _____ Referred by:_____

Marital Status: _____ Name of Spouse: _____

Emergency Contact: _____ Phone: _____

Medical History (Please Circle)

Y N Heart trouble/Heart Murmur
Y N Rheumatic Fever
Y N Heart Disease/ Defect
Y N Heart Attack/Stroke
Y N Irregular Heart Beat
Y N High Blood Pressure
Y N Pacemaker
Y N Prosthetic Heart Valve
Y N Chest Pain
Y N Shortness of Breath
Y N Asthma/ Emphysema
Y N Tuberculosis
Y N Cancer
Y N Radiation/Chemotherapy
Y N Diabetes/Sugar
Y N Venereal Disease
Y N Immunocompromised
Y N AIDS/HIV Positive
Y N Arthritis

Y N Stomach Ulcers
Y N Kidney Problems
Y N Thyroid Disease
Y N Glaucoma/Visual
Y N Epilepsy/Seizures/Convulsions
Y N Psychiatric Therapy
Y N Blood Disorders
Y N Denied Blood Donation
Y N Anemia
Y N Blood transfusion
Y N Hepatitis/Jaundice
Y N Artificial Bones
Y N Joint Replacement
Y N Prosthetic Implant
Y N Any Transplant
Y N Recent Weight Change
Y N Excessive Thirst
Y N Alcohol/Drug Abuse
Y N Surgery

Height:_____Weight:_____

Patient Registration

Do you require Pre-medication with antibiotics prior to dental treatment? □ Y or □ N

Are you currently under the care of a physician? □Y or □ N
Describe condition: _____

Have you been hospitalized or had a serious illness within the past five years? □Y or □ N
Describe: _____

Are you taking any medication(s) including non-prescription medicine? □ Y or □ N

Medications: _____

_____

_____

Has there been a change in your health within the last year? □ Yes □ No
Describe: _____

Is there anything else that we should know about your Medical History? □ Y or □ N
Describe:_____

Are you allergic or had a reaction such as: itching, rash swelling of hands/feet/eyes to:
□ Novocain/dental anesthetic? □ Codeine or other narcotics □ Latex Allergy? □Penicillin ? □ Other?

ORAL HEALTH HISTORY

- History of fever blisters / cold sores / ulcers / canker sores? □Y or □ N
- Have you had any trouble with previous dental treatment? □Y or □ N
- Do you have any disease, condition, or problem not listed? □Y or □ N
  If yes, please specify:_____

WOMEN

- Are you pregnant or anticipating pregnancy in the near future? □Y or □ N
- Are you taking birth control pills? □Y or □ N

SOCIAL HISTORY

- Do you smoke? □Y or □ N Do you use alcohol? □Y or □ N

I certify that I have read and understand the above. If I have any change in my health, or if my medications change, I will inform the doctor and his staff at the next appointment.

_____
Signature of Patient/ Guardian Date

Patient Registration

IF YOU DO NOT HAVE DENTAL INSURANCE PLEASE LEAVE THIS BLANK

Primary Dental Insurance Information

Subscriber's Name: _____ Date of Birth _____
ID # or Social Security #: _____

Insurance Co. _____ Group # _____
Address: _____ Phone: ( ) _____
_____

Employer: _____ Phone ( ) _____
Address: _____
_____

Relationship to Subscriber Self Spouse Dependent

Secondary Dental Insurance Information

(NOT MEDICAL INSURANCE)

Subscriber's Name: _____ Date of Birth _____
ID# or Social Security #: _____

Insurance Co. _____ Group # _____
Address: _____ Phone ( ) _____
_____

Employer: _____ Phone ( )_____
Address: _____
_____

Relationship to Subscriber Self Spouse Dependent