PATIENT REGISTRATION AND MEDICAL HISTORY

(PLEASE PRINT)

Date ____________

Patient ____
Last Name First Name Initial Preferred Name

Cell Phone ____________ Home Phone ____________ Email ____________

Street Address ____________ City ____________ State ______ Zip ______

Sex ☐ M ☐ F Age ______ Birth date ____________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed by ____________ Occupation ____________

Business Address ____________ Business Phone ____________

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 ____________

In case of emergency, who should be notified? ____________ Phone ____________

Whom may we thank for referring you? ____________

Physician's Name ____________ Date of Last Physical ____________

Have you ever had any of the following? (check boxes that apply):

- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Artificial Heart Valves or Joints
- ☐ Recent Weight Loss
- ☐ Back Problems
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Cancer
- ☐ Psychiatric Care
- ☐ Chronic Diarrhea
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ General Allergies
- ☐ Blood Disease
- ☐ Arthritis
- ☐ Special Diet
- ☐ Swollen Neck Glands
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ HIV / AIDS
- ☐ Thyroid Disease
- ☐ Stroke
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Hemophilia

Do you have any allergies or adverse reactions to medication? ☐ Yes ☐ No If so, what? ____________

Are you taking any medications at this time? ☐ Yes ☐ No If so, what? ____________

Are you currently under the care of a physician? ☐ Yes ☐ No If so, for what? ____________

Have you ever been told to premedicate prior to dental treatment? ☐ Yes ☐ No

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Anything else we should know about your medical or dental 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 other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date ____________ **Signature** ____________