Patient Registration and Information

DATE_____ (PLEASE PRINT)

Patient _____
Last Name First Name Initial "Nickname"

Street Address _____ City_____ State_____ Zip_____

Phone : Home(___) _____ Work (___) _____ Cell (___)_____

Sex ☐ M ☐ F Birthdate _____ ☐ Single☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed by _____ Occupation_____ Email_____

Business Address _____ Patient S.S. # _____

Spouse Name _____

Spouse Employed by _____ Occupation _____

Business Address _____ Business Phone _____

In case of emergency, who should be notified? _____ Phone (___) _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

MEDICAL HISTORY

Physician Name _____Phone _____ Date of Last Physical _____

Address _____ City/State _____ Zip _____

Date of Last Dental Exam _____ Date of Last Dental X-rays _____

Have you ever had any of the following?

Y	N		Y	N		Y	N	
☐	☐	Physician Recommended Antibiotics Prior to Dental Treatment Dr's Name _____	☐	☐	Asthma	☐	☐	High Cholesterol
			☐	☐	Bleeding Problems	☐	☐	HIV / AIDS
			☐	☐	Blood Transfusion Date_____	☐	☐	Latex Allergy
☐	☐	Mitral Valve Prolapse	☐	☐	Cancer _____ Date_____	☐	☐	Mental Health Disorders
☐	☐	Joint Replacement: hip/knee/ other Date _____	☐	☐	Chemotherapy/Radiation Treatment			Specify _____
			☐	☐	Cigarettes/Cigars/Chewing Tobacco	☐	☐	Metal Allergy
☐	☐	Rheumatic Fever	☐	☐	Diabetes	☐	☐	Migraines/ Severe Headaches
☐	☐	Heart Murmur			☐ Type I (insulin dependent)	☐	☐	Nervous / Anxiety Problems
☐	☐	Pacemaker/Heart Valve Replacement			☐ Type II	☐	☐	Persistent Swollen Neck Gland
☐	☐	High / Low Blood Pressure (Circle)	☐	☐	Eating Disorder Specify _____	☐	☐	Rapid Weight Loss
☐	☐	Heart Problems/ Heart Attack _____	☐	☐	Epilepsy/ Seizure Disorders	☐	☐	Sexually Transmitted Disease
☐	☐	Alcohol/ Drug Dependency	☐	☐	Fainting Spells			_____
☐	☐	Allergies to Local Anesthetics	☐	☐	General Allergies	☐	☐	Sinus Problems
☐	☐	Allergy:Aspirin/Penicillin/Codeine(circle)	☐	☐	GI Problems-GE Reflux / Ulcer	☐	☐	Sleep Disorder
☐	☐	Antidepressant Medications	☐	☐	Hemophilia	☐	☐	Stroke
☐	☐	Arthritis	☐	☐	Hepatitis __/Jaundice/Liver Disease (circle)	☐	☐	Tuberculosis/Persistant Cough

Have you had an allergic or adverse reaction to medication? List: _____

_____

Have you ever responded adversely to medical or dental treatment? _____

List all medications taken routinely or "as needed" _____

_____

Are you under the care of a physician? For what conditions? _____

Do you suspect that you are pregnant? ☐ Yes ☐ No Taking Birth Control Pills ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Is there anything else we should know about your medical history? _____

How do you feel about the appearance of your teeth? _____

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 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 I may have made in the completion of this form.

Date _____ Signature _____

New Medications / Changes in your health ____
Are you happy with your smile? ____________ Why? ______________________________________
Date ____________________ Signature ________________________________ Reviewed By: ____________

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