PATIENT REGISTRATION AND MEDICAL HISTORY

Date_____ Cell Phone_____ Home Phone_____

Patient _____
Last Name First Name Initial Preferred Name

Street Address_____City_____State_____Zip Code_____

E-mail address _____

Sex: M F Age_____Birthdate_____ Single Married Widowed Separated Divorced

Employed By_____Occupation_____

Business Address_____Business Phone_____

Spouse Name_____Spouse Birthdate_____

Spouse Employed By_____Occupation_____

Business Address_____Business Phone_____

Who is responsible for the account?_____Relationship to Patient_____

SS#_____Spouse's SS#_____

Name of Dental Insurance Company_____Group #_____

In case of emergency, who should be notified?_____

Whom may we thank for referring you?_____

MEDICAL HISTORY

Physician's Name_____Date of Last Physical_____

Have you ever had any of the following?

O Heart problems
O High Blood Pressure
O Low Blood Pressure
O Circulatory Problems
O Nervous Problems
O Radiation Treatment
O Artificial Heart Valves or Joints
O Recent weight loss
O Back Problems
O Diabetes
O Respiratory Disease
O Epilepsy
O Headaches
O Hepatitis, Jaundice or Liver Disease
O Cancer
O Psychiatric Care
O Chronic Diarrhea
O Allergies to Anesthetics
O Allergies to Medicine or Drugs
O General Allergies
O Blood Disease
O Arthritis
O Special Diet
O Swollen Neck Glands
O Rheumatic Fever
O Sinus Problems
O "A.I.D.S." or Other Disorders
O Stroke
O Ulcer
O Venereal Disease
O Chemical Dependency
O Hemophilia

OVER ⇒

Do you have any allergies or have you ever had an adverse reaction to any medication?_____If so, what

_____

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

Are you taking any medication at this time?_____If so, what_____

Are you under the care of a physician? Yes No

For what conditions?_____

Do you use tobacco?_____What form?_____How much?_____

If the patient is a child what is his/her weight?_____

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

Is there anything else we should know about your medical

history?_____

NOTE: If for any reason the account should become delinquent, I agree to pay all collection and legal fees.

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 members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____Signature_____