PATIENT REGISTRATION AND MEDICAL HISTORY

(PLEASE PRINT)

Date _____ Home Phone (_____)_____ Cell Phone (_____)_____

Patient _____
Last Name First Name Initial Preferred Name

Street Address _____ City _____ State _____ Zip _____

E-mail Address _____

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

Employed by _____ Occupation _____

Business Address _____ Business Phone (_____)_____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

Spouse/Parent Employed by _____ Occupation _____

Business Address _____ Business Phone (_____)_____

Who is responsible for this account? _____ Relationship to Patient_____

Social Security # _____ Spouse/Parent's Social Security # _____

Name of Dental Insurance Co. _____ Group # _____ Phone# _____

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____

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

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____

Have you ever had any of the following? (Check ALL boxes either YES or NO):

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Asthma	☐	☐	Glaucoma	☐	☐	Blood Disease	☐	☐	Do you snore?
☐	☐	Mitral Valve Prolapse	☐	☐	Kidney Disease	☐	☐	Hemophilia	☐	☐	Has anyone ever stated that you stop breathing or gasp during sleep?
☐	☐	Rheumatic Fever	☐	☐	Epilepsy	☐	☐	Arthritis	☐	☐	Do you wake up and feel refreshed?
☐	☐	Pacemaker	☐	☐	Headaches	☐	☐	Tuberculosis	☐	☐	Are you aware of grinding or clenching your teeth?
☐	☐	Latex Allergy	☐	☐	Hepatitis, Jaundice or Liver Disease	☐	☐	Swollen Neck Glands			
☐	☐	Excessive Bleeding	☐	☐	Blood Thinners	☐	☐	Sinus Problems			
☐	☐	Heart Problems	☐	☐	Cancer	☐	☐	HIV/AIDS or other Immunosuppressive Disorders			
☐	☐	High Blood Pressure	☐	☐	Psychiatric Care	☐	☐	Stroke			
☐	☐	Low Blood Pressure	☐	☐	Allergies to Anesthetics	☐	☐	Ulcer			
☐	☐	Circulatory Problems	☐	☐	Allergies to Medicine or Drugs	☐	☐	Venereal Disease			
☐	☐	Radiation Treatment	☐	☐	Allergies to Penicillin	☐	☐	Chemical Dependency			
☐	☐	Artificial Heart Valves	☐	☐	Allergies to Tetracycline	☐	☐	Dizziness			
☐	☐	Artificial Joint	☐	☐	General Allergies	☐	☐	Thyroid Problems			
☐	☐	Diabetes	☐	☐	Heart Murmur	☐	☐	History of Tobacco use			
☐	☐	Respiratory Disease	☐	☐	Mental Disorders						

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

_____

Have you ever been told that you need to be Pre-Medicated? ☐ Yes ☐ No

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

Are you taking any medication at this time? ☐ Yes ☐ No If so, what _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin(brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Are you under the care of a physician? ☐ Yes ☐ No For what conditions? _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

(WOMEN) Do you suspect that you are pregnant? ☐ Yes ☐ No Due Date _____ Are you nursing? ☐ Yes ☐ No

Are you currently taking birth control pills? ☐ Yes ☐ No (certain medications interfere with oral contraceptives)

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

The above information is accurate and complete to the best of my knowledge. Since a change in medical condition or medications can effect dental treatment, I understand the importance of, and agree to any changes at any subsequent appointment. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____ _____ _____
Signature of Patient, Parent or Guardian Date Doctor's Signature Date