

PATIENT REGISTRATION

Date: _____

Patient Information

First Name: _____ Last Name: _____ M.I. _____

What do you prefer to be called: _____

Address: _____ Address 2: _____

City: _____ State/Zip: _____

Home Phone: _____ Work Phone: _____ Ext. _____ Cell: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ I would like to receive correspondences via e-mail.

Employment Status: Full Time Part Time Retired

Emergency Contact: _____

Student Status: Full Time Part Time

Emergency Contact #: _____

Prof. Pharmacy: _____

Referred By: _____

Prof. Hyg.: _____

Previous Dentist: _____

Responsible Party (if someone other than the patient)

Patient is: Policy Holder Responsible Party

First Name: _____ Last Name: _____

Address: _____ Address 2: _____

City/State/Zip: _____

Home Phone: _____ Work Phone: _____ Ext. _____ Cell: _____

Birth Date: _____ Soc. Sec: _____ Drivers Lic: _____

Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured: _____ Relationship to insured: Self Spouse Child Other

Insured Soc. Sec.: _____ Insured Birth Date: _____

ID #: _____

Ins. Company: _____

Group #: _____

Address: _____

Employer: _____

Address 2: _____

Occupation: _____

City, State, Zip: _____

Phone: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to insured: Self Spouse Child Other

Insured Soc. Sec.: _____ Insured Birth Date: _____

ID #: _____

Ins. Company: _____

Group #: _____

Address: _____

Employer: _____

Address 2: _____

Occupation: _____

City, State, Zip: _____

Phone: _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Women: Are you _____

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following? _____

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: _____

Do you have, or have you had, any of the following? _____

| | | | |
|--|--|---|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No Anemia <input type="radio"/> Yes <input type="radio"/> No Angina <input type="radio"/> Yes <input type="radio"/> No Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No Artificial Joint <input type="radio"/> Yes <input type="radio"/> No Asthma <input type="radio"/> Yes <input type="radio"/> No Blood Disease <input type="radio"/> Yes <input type="radio"/> No Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No Breathing Problem <input type="radio"/> Yes <input type="radio"/> No Bruise Easily <input type="radio"/> Yes <input type="radio"/> No Cancer <input type="radio"/> Yes <input type="radio"/> No Chemotherapy <input type="radio"/> Yes <input type="radio"/> No Chest Pains <input type="radio"/> Yes <input type="radio"/> No Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No Yes <input type="radio"/> No | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No Diabetes <input type="radio"/> Yes <input type="radio"/> No Drug Addiction <input type="radio"/> Yes <input type="radio"/> No Easily Winded <input type="radio"/> Yes <input type="radio"/> No Emphysema <input type="radio"/> Yes <input type="radio"/> No Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No Frequent Coughs <input type="radio"/> Yes <input type="radio"/> No Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No Genital Herpes <input type="radio"/> Yes <input type="radio"/> No Glaucoma <input type="radio"/> Yes <input type="radio"/> No Hay Fever <input type="radio"/> Yes <input type="radio"/> No Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No Heart Murmur <input type="radio"/> Yes <input type="radio"/> No Heart Pace Maker <input type="radio"/> Yes <input type="radio"/> No Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No Hepatitis A <input type="radio"/> Yes <input type="radio"/> No Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No Herpes <input type="radio"/> Yes <input type="radio"/> No High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No Hives or Rash <input type="radio"/> Yes <input type="radio"/> No Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No Kidney Problems <input type="radio"/> Yes <input type="radio"/> No Leukemia <input type="radio"/> Yes <input type="radio"/> No Liver Disease <input type="radio"/> Yes <input type="radio"/> No Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No Lung Disease <input type="radio"/> Yes <input type="radio"/> No Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No Rheumatism <input type="radio"/> Yes <input type="radio"/> No Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No Shingles <input type="radio"/> Yes <input type="radio"/> No Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No Spina Bifida <input type="radio"/> Yes <input type="radio"/> No Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No Stroke <input type="radio"/> Yes <input type="radio"/> No Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No Tonsillitis <input type="radio"/> Yes <input type="radio"/> No Tuberculosis <input type="radio"/> Yes <input type="radio"/> No Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No Ulcers <input type="radio"/> Yes <input type="radio"/> No Venereal Disease <input type="radio"/> Yes <input type="radio"/> No Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No |
|--|--|---|---|

Yes No Have you ever taken, or are you currently taking Fosamax, Boniva, Actonel, Skelid, Aredia or Zometa?

Yes No Have you ever been premedicated for dental tx?

Have you ever had any serious illness not listed above? Yes No If yes, please explain _____

List medications (prescriptions, non-prescription drugs and vitamins currently being taken): _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to informed he dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____