PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____

Patient is: ☐ Policy Holder
☐ Responsible Party

Responsible Party (if other than patient) _____
First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____
City, State, Zip: _____
Home# _____ Work # _____ Ext: _____ Cellular# _____
Birth Date: _____ Soc. Sec.# _____ Drivers Lic: _____
○ Responsible Party is also Policy Holder for Patient ○ Primary Ins Policy Holder ○ Secondary Ins Policy Holder

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Patient Information

Address: _____
City, State, Zip: _____
Home# _____ Work # _____ Ext: _____ Cellular# _____
Sex: ○ Male ○ Female Marital Status: ○ Married ○Single ○ Divorced ○ Separated ○ Widowed
Birth Date: _____ Age: _____ Soc. Sec.# _____ Drivers Lic: _____
E-Mail: _____☐ I would like to receive correspondence via e-mail

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Employment Status: ○ Full Time ○ Part Time ○ Retired Referred By: _____
Student Status: ○ Full Time ○ Part Time Previous Dentist: _____
Employer ID: _____
Carrier ID: _____

Primary Insurance Information
Name of Insured: _____Relationship to Insured: ○Self ○Spouse ○Child ○ Other
Insured Soc. Sec: _____ Birth Date: _____
Employer: _____ Ins. Company: _____
Address: _____ Address: _____
_____ _____
City,State,Zip: _____ City,State,Zip: _____

Secondary Insurance Information
Name of Insured: _____Relationship to Insured: ○Self ○Spouse ○Child ○ Other
Insured Soc. Sec: _____ Birth Date: _____
Employer: _____ Ins. Company: _____
Address: _____ Address: _____
_____ _____
City,State,Zip: _____ City,State,Zip: _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications 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	If yes, please explain: _____
Are you on a special diet?	○ Yes ○ No	If yes, please explain: _____
Do you use tobacco?	○ Yes ○ No	If yes, please explain: _____
Do you use controlled substances?	○ Yes ○ No	If yes, please explain: _____

Women: Are you
☐ Pregnant/Trying to get pregnant? ☐ Nursing?
☐ Taking oral contraceptives?

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	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizure	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatment	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

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

Comments: _____
_____
_____
_____
_____
_____
_____

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 inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____