

PLEASE ANSWER ALL QUESTIONS AND SIGN THIS FORM UPON COMPLETION

Date of last Physical exam _____

Have you had any serious illnesses in the past three years? Y N
If so, please explain _____

Are you under a physician's care? Y N
If so, for what condition?
Please list the Name, Address, Phone Number of your Physician:

Do you have or have you had any of the following conditions or diseases?

CARDIOVASCULAR

Rheumatic Fever Y N
Congenital Heart Defect Y N
Angina or Heart Attack Y N
Heart Murmurs Y N
Mitral Valve Prolapse Y N
Congestive Heart Failure Y N
Heart Surgery or Pacemaker Y N
High or Low Blood Pressure Y N

RESPIRATORY DISEASE

Asthma Y N
Emphysema Y N
Hay Fever or Sinusitis Y N

ENDOCRINE DISORDERS

Diabetes Y N
Hyperthyroidism (high thyroid) Y N
Hypothyroidism (low thyroid) Y N

BLOOD DISORDERS

Anemia Y N
Bleed excessively when cut? Y N

KIDNEY DISEASE

Kidney Infections Y N
Have you had kidney surgery? Y N

INFECTIOUS DISEASES

Hepatitis Y N
Venereal Disease Y N
Tuberculosis Y N
HIV Positive Y N
AIDS Y N

MISCELLANEOUS DISEASES & DISORDERS

Frequent fainting Y N
Liver Disease Y N
Arthritis Y N
Ulcers Y N
Glaucoma Y N
Epilepsy Y N
Cancer or Radiation Therapy Y N
Prosthetic Joint Y N

Are you required to take premedication for any heart condition or artificial joint? Y N

Physician Name: _____ **PH:** _____

Preferred Pharmacy: _____ **PH:** _____

Blood Thinners Y N
Steroids or Cortisone Y N
High Blood Pressure Medicines Y N
Aspirin Y N
Tranquilizers Y N

Please list all the prescribed medicines

that you are now taking: Reason:

Do you have any **ALLERGY** or **REACTION** to any of the following medications?

Latex Y N
Local Anesthetics Y N
Penicillin Y N
Other Antibiotics: _____ Y N
Codeine Y N
Other Pain Med: _____ Y N
Aspirin Y N
Barbiturates or Sedatives Y N

Any Other Medicines _____

Have you ever worn braces? Y N
Have you ever had gum surgery? Y N
Have you had difficulty with any dental work or extractions? Y N

Do you have any medical problem not listed above? Y N

WOMEN ONLY

Are you pregnant? Y N
If so, when are you due? _____

All the information that I have given above is accurate to the best of my knowledge:

Please sign and date this form

Today's Date: _____

Patient's Name: _____

Complete Address: _____

Social Security Number: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

EMPLOYER INFORMATION:

Employer: _____

Employer Address: _____

Employer Phone Number: _____

Job Title: _____ How Long Held: _____

INSURANCE INFORMATION:

Subscribers Name: _____ Date of Birth: _____

Social Security Number: _____

Relationship to Patient: _____

Insurance Company Name: _____

Claims Mailing Address: _____

Claims Phone Number: _____ Policy/Group #: _____

EMERGENCY INFORMATION:

Nearest Relative Not Living with Patient: _____

Address: _____

Relationship: _____ Home Phone: _____ Cell Phone: _____

Whom May We Thank for Your Referral to Us? _____

I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE AND THAT I AM ACCEPTING FINANCIAL RESPONSIBILITY FOR ALL CHARGES INCURRED BY THE PATIENT NAMED ABOVE.

Signature

Date

Adult Patient Registration