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: _____
Home Phone: _____ Cell Phone: _____

RESPONSIBLE PARTY INFORMATION:

Name: _____
Address: _____
Relationship to Patient: _____
Social Security Number: _____ Date of Birth: _____
Employer: _____
Employer Address: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address: _____

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 RESPONSIBILTY FOR ALL CHARGES INCURRED BY THE PATIENT NAMED ABOVE.

_____ _____
Signature Date

Child Patient Registration