



REGISTRATION & MEDICAL HISTORY

PATIENT INFORMATION

Date _____

Date of Birth: _____
Month Day Year

Patient: _____
Last First M.I. M F Single Married Divorced Child

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____ Ext. _____

Pager # _____ Cellular # _____

Insurance Co.: _____ SS #: _____

Employer: _____ Driver's License #: _____

Address: _____ Occupation: _____

Emergency Contact: _____ Phone #: _____

Referred By: _____ Interest/Hobby: _____

MEDICAL HISTORY

Have you ever had any of the following? (check yes or no)

- | | | | |
|--|---|--|--|
| Y N | Y N | Y N | Y N |
| <input type="checkbox"/> <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Heart Attack | <input type="checkbox"/> <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> <input type="checkbox"/> Arthritis/Lupus |
| <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Blood Disease | <input type="checkbox"/> <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> <input type="checkbox"/> Pace Maker | <input type="checkbox"/> <input type="checkbox"/> Asthma/Emphysema | <input type="checkbox"/> <input type="checkbox"/> Liver Disease | <input type="checkbox"/> <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve or Joints | <input type="checkbox"/> <input type="checkbox"/> Epilepsy | <input type="checkbox"/> <input type="checkbox"/> Hemophilia | <input type="checkbox"/> <input type="checkbox"/> Alcohol, Narcotics, Prescription Drugs |
| <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Allergic to Anesthetic | <input type="checkbox"/> <input type="checkbox"/> HIV Positive | <input type="checkbox"/> <input type="checkbox"/> Pregnant (current) |
| <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Allergic to Medicine or Drugs | <input type="checkbox"/> <input type="checkbox"/> A.I.D.S | <input type="checkbox"/> <input type="checkbox"/> Birth Control Pills (current) |
| <input type="checkbox"/> <input type="checkbox"/> Stroke | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> <input type="checkbox"/> Smoke |
| | | <input type="checkbox"/> <input type="checkbox"/> Cancer | |

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

Physicians Name _____ Phone # _____ Date of last visit _____

Do you have any drug allergies or have you had an adverse reaction to medication? Yes No

If so, what? _____

Are you presently taking any medications / vitamins? Yes No

If yes, please list? _____

If child, weight: _____

Do you have any medical condition not listed above? Yes No

If yes, please list: _____

The reason you left the previous dentist: _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. 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.

Date _____ Signature _____ **OVER**