PATIENT REGISTRATION AND MEDICAL HISTORY

Preferred Contact

Home Phone _____ ❑
Work Phone _____ ❑
Cell Phone _____ ❑
E-Mail _____ ❑

Date _____ (PLEASE PRINT)

Patient _____
Last Name First Name Initial Preferred Name

Home Address _____

Sex: ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Employed by (or Parent employed by) _____ Occupation _____ (Parent Birthdate) _____

Business Address _____ Business Phone _____

Spouse Name _____ Spouse Birthdate _____

Spouse Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Who is responsible for this account? _____ Relationship to Patient _____

Social Security # _____ Spouse's Social Security # _____

Name of Dental Insurance _____ Group # _____ Phone _____

Spouse's Insurance _____ Group # _____ Phone _____

In case of emergency, who should be notified? _____ Phone _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____ Today's BP _____

Are you generally in good health ❑ Yes ❑ No
Have you ever had any of the following?

Yes	No		Yes	No		Yes	No	
❑	❑	Heart Murmur	❑	❑	Tuberculosis	❑	❑	Glaucoma
❑	❑	Heart Problems	❑	❑	Epilepsy	❑	❑	Special Diet
❑	❑	High Blood Pressure	❑	❑	Headaches	❑	❑	Taken Fen Phen
❑	❑	Low Blood Pressure	❑	❑	Hepatitis, Jaundice, Liver Disease	❑	❑	Swollen Neck Glands
❑	❑	Circulatory Problems	❑	❑	Cancer	❑	❑	Rheumatic Fever
❑	❑	Nervous Problems	❑	❑	Psychiatric Care	❑	❑	Sinus Problems
❑	❑	Radiation Treatment	❑	❑	Latex Allergies	❑	❑	"A.I.D.S." or Other Immunosuppressive Disorders
❑	❑	Artificial Heart Valves	❑	❑	Allergies to Anesthetics			
❑	❑	Recent Weight Loss	❑	❑	Allergies to Medicine or Drugs	❑	❑	Stroke
❑	❑	Back Problems	❑	❑	General Allergies	❑	❑	Ulcer
❑	❑	Diabetes	❑	❑	Blood Disease	❑	❑	Sexually Transmitted Disease
❑	❑	Respiratory Disease	❑	❑	Arthritis	❑	❑	Chemical Dependency
❑	❑	Asthma	❑	❑	Kidney Diseases	❑	❑	Hemophilia
❑	❑	Taken Biphosphonates or Fosamax				❑	❑	Joint Replacement or Implant
						❑	❑	Other

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____ If so, what? _____

_____

Have you ever responded adversely to medical or dental treatment? _____

Are you taking any medication (including non prescription medication) at this time? _____ If so, what? _____

Are you under the care of a physician? ❑ Yes ❑ No

For what conditions? _____

(Woman) Do you suspect that you are pregnant? ❑ Yes ❑ No Are you nursing ❑ Yes ❑ No Are you taking birth control pills? ❑ Yes ❑ No

Is there anything else we should know about your medical history? _____

_____

The above information is accurate and complete to t he 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 _____

Whom can we thank for this referral? _____

Is there anything else we need to know about you? _____

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?______________________________ Today's BP____________

Are you taking any new medications?________ If so, what ______________________________

Date *Signature*

Date *Doctor's Signature*

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?______________________________ Today's BP____________

Are you taking any new medications?________ If so, what ______________________________

Date *Signature*

Date *Doctor's Signature*

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?______________________________ Today's BP____________

Are you taking any new medications?________ If so, what ______________________________

Date *Signature*

Date *Doctor's Signature*

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?______________________________ Today's BP____________

Are you taking any new medications?________ If so, what ______________________________

Date *Signature*

Date *Doctor's Signature*