MARK J. ANDREWS, D.D.S.
PATIENT REGISTRATION UPDATE
All information is CONFIDENTIAL

Email Address _____

Home Phone _____

Patient _____ Birthdate _____ Work Phone _____
LAST NAME FIRST NAME INITIAL

Address _____ Age _____ Mobile Phone _____

_____ Social Security No. _____
CITY STATE ZIP CODE

Spouse's Name or Parent if a minor _____

Person Responsible for Account _____

MEDICAL HISTORY

In case of emergency, notify _____
NAME PHONE RELATIONSHIP

Name, Address, & Phone# of Physician _____

Do you have or have you had any of the following: *[Check the appropriate box(es)]*

- ☐ Allergies to Anesthetics
- ☐ Allergies to Medication
- ☐ Allergies to _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
  Type_____
- ☐ Diabetes
- ☐ Dry Mouth
- ☐ Epilepsy
- ☐ Excessive Bleeding/Bruising
- ☐ Fibromyalgia
- ☐ Heart Murmur
- ☐ Heart Trouble
- ☐ Heart Valve Replacement
- ☐ Hepatitis
- ☐ High/low Blood Pressure
- ☐ HIV Positive
- ☐ Joint(s) Replacement
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Mitral Valve Prolapse
- ☐ M.S.
- ☐ Osteoporosis
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Stroke(s)
- ☐ Sjögren's
- ☐ Surgery
- ☐ Thyroid Problem
- ☐ Tuberculosis

Please list all medication you are taking _____

_____

Are you pregnant? ☐ Yes ☐ No

Are the any other medical conditions that may possibly affect your dental treatment? ☐ Yes ☐ No

If yes please describe _____

_____

I understand that the total payment of the fee for dental services is my responsibility and not that of the insurance company. I agree to pay for all services rendered.

Signature _____ Date _____