Health History and Registration

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PATIENT NAME:____________________________BIRTHDAY:______________SEX____SS#________________________________
ADDRESS:______________________________CITY:_____________________________STATE:_______ZIP: __________________
HOME PHONE: _________________WORK #:_____________CELL #:______________E MAIL:__________________________
REFERRED BY: ___________________________EMPLOYER: ________________________OCCUPATION:_________________
EMPLOYER ADDRESS:__________________________ MARITAL STATUS:_____ CHILDREN:_______ SPOUSES NAME:____________
IF PATIENT IS A CHILD, PARENTS NAME:__________________________ PARENT'S WORK PHONE :_______________________
PERSON RESPONSIBLE FOR ACCOUNT: ________________________IN CASE OF EMERGENCY; CALL:_______________ PH:______________

DO YOU HAVE DENTAL INSURANCE: YES NO

PRIMARY SUBSCRIBER'S NAME:________________________ SS#______________ SUBSCRIBER'S BIRTHDAY________________________
GROUP #:__________SUBSCRIBER'S EMPLOYER:_________________ EMPLOYER'S ADDRESS:_______________________________
INSURANCE COMPANY NAME & ADDRESS:____

DO YOU HAVE SECONDARY COVERAGE: YES NO

SECONDARY SUBSCRIBER'S NAME: ________________________SS#________________ SUBSCRIBER'S BIRTHDAY__________________
GROUP #: __________SEC SUBSCRIBER'S EMPLOYER______________________ EMPLOYER'S ADDRESS: __________________________
INSURANCE COMPANY NAME & ADDRESS: ____

MEDICAL HISTORY

1. WHEN WAS YOUR LAST PHYSICAL EXAM? ____
2. ARE YOU IN GOOD HEALTH? ____
3. PHYSICIAN'S NAME: ____________________________PHYSICIAN PHONE#:____________________________
4. ARE YOU UNDER HIS/HER CARE NOW? **Y- N IF YES, FOR WHAT REASON OR CONDITION? ______________________________**
5. DO YOU TAKE ASPIRIN ON A REGULAR BASIS? **YES OR NO**
6. LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING AND WHAT THEY ARE FOR:

______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________

ARE YOU ALLERGIC TO THESE OR ANY OTHER SUBSTANCES? YES NO

PLEASE CIRCLE

ASPIRIN, ERYTHROMYCIN, PENICILLIN, SULPHA DRUGS – OTHER ANTIBIOTICS – LOCAL ANESTHETIC (NOVACAINE, XYLOCAINE, ETC.)
CODEINE, NARCOTICS, SEDATIVES OR OTHER ____
HAVE YOU HAD ANY SERIOUS ILLNESS, HOSPITALIZATION OR SURGERY IN THE PAST 5 YEARS? **YES NO PLEASE DESCRIBE**

____
____

DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK YES OR NO

	YES NO		YES NO		YES NO
RHEUMATIC FEVER -	___ ___	RESPIRATORY DISEASE -	___ ___	ARTIFICIAL JOINT OR JOINT SURGERY -	___ ___
HEART MURMUR -	___ ___	TUBERCULOSIS -	___ ___	KIDNEY DISEASE -	___ ___
MITRAL VALVE PROLAPSE -	___ ___	PERSISTENT COUGH -	___ ___	THYROID DISEASE -	___ ___
HEART DISEASE -	___ ___	SINUS PROBLEMS -	___ ___	AIDS, HIV +, ARC -	___ ___
WHAT TYPE? -	___ ___	ASTHMA -	___ ___	VENEREAL DISEASE -	___ ___
ARTIFICIAL HEART VALVE -	___ ___	DIGESTIVE PROBLEMS -	___ ___	EPILEPSY / SEIZURES -	___ ___
PACEMAKER -	___ ___	ULCERS -	___ ___	FAINTING / DIZZINESS -	___ ___
HIGH BLOOD PRESSURE -	___ ___	HIATAL HERNIA -	___ ___	TUMORS OR GROWTH -	___ ___
LOW BLOOD PRESSURE -	___ ___	HEART BURN -	___ ___	CANCER / TYPE - _______	___ ___
CIRCULATION PROBLEMS -	___ ___	REFLUX -	___ ___	CHEMOTHERAPY -	___ ___
ANEMIA -	___ ___	LIVER PROBLEMS -	___ ___	RADIATION TREATMENT -	___ ___
STROKE -	___ ___	HEPATITIS A (INFECTIOUS) -	___ ___	A-V SHUNTS -	___ ___
EXCESSIVE BLEEDING -	___ ___	B (SERUM) -	___ ___		
BLOOD TRANSFUSION -	___ ___	FREQUENT HEADACHES -	___ ___		
DIABETES -	___ ___	ARTHRITIS -	___ ___		

7. DO YOU USE TOBACCO PRODUCTS? **Y- N** WHAT KIND? ____________________________HOW OFTEN?______________________
8. DO YOU HAVE A DISEASE OR PROBLEM NOT LISTED ABOVE? ____

PLEASE EXPLAIN ____

WOMEN: ARE YOU PREGNANT? **Y - N**
ARE YOU TAKING BIRTH CONTROL PILLS? **Y - N**
ARE YOU NURSING? **Y- N**

PATIENT SIGNATURE: _________________________DATE:____________________

MEDICAL ALERT