MICHAEL B. COPP, D.D.S.

REGISTRATION AND HEALTH HISTORY

Name ____
(Last) (First) (Middle Initial) (Preferred Name)

SS# ____________ Birthdate ____________ Sex ____________ Cell Phone # ____________

Address ____ Home Phone # ____________

City ____________________________________ State ____________ Zip ____________

Employer ____________________________________ Employers' Phone ____________

Parent or Spouse Name ____________________ Birthdate ____________ SS# ____________

Parent or Spouse's Employer ____________________________ Employers' Phone ____________

Whom may we thank for referring you ____

Name & Address of your Dental Ins. Co ____

Subscriber Name & SS# ____________________________________ Grp # ____________

Name & Address of Secondary Dental Ins. Co ______________________________________

Subscriber name & SSN # ____________________________________ Grp # ____________

DENTAL AND MEDICAL HISTORY

Physicians Name and Phone # ____

Are you having any discomfort at this time? ____________________ If yes , for how long? ____________

How long since you have been to a dentist? ____________________ What was done? ____________

Have you had any gum treatment? ____________________ If yes, what was done? ____________

Have you ever had a problem with TMJ(jaw joint)? ____________________ If yes, when? ____________

Do you have,or ever had any allergies or adverse reactions to medication? _____ If yes, to what? ____________

Are you taking any medications at this time? _______ If yes , please list ____________________

Have you ever taken orally or intravenously any of the following :Fosamax, Boniva, Aredia, Actonel, Zometa, Didronel, Skelid or any other bisphophonates *(please circle)* ____

Do you have any of the following? Please circle either Y(es) or N(o)

Heart Murmur	Y N	Aids or related complex	Y N	Epilepsy	Y N
Mitral Valve Prolapse	Y N	Arthritis	Y N	Psychiatric care	Y N
Artificial Heart Valve or Joint	Y N	Anemia	Y N	Chemical Dependency	Y N
Heart Attack or Stroke	Y N	Asthma	Y N	Sinus Problems	Y N
Low Blood Pressure	Y N	Diabetes	Y N	Tuberculosis	Y N
High Blood Pressure	Y N	Hemophilia	Y N	Ulcer	Y N
Cancer	Y N	Hepatitis, Jaundice	Y N	Liver Disease	Y N
Radiation Treatment	Y N	Excessive Bleeding	Y N		

Women : Do you expect that you are pregnant? ____________________ Are you Nursing? ____________________

Please describe any current medical treatments, impending operations or any other medical or dental information that may possibly affect your dental treatment ____

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Signature ____ Date ____________________