BRUCE M. HOLT, D.D.S., Inc.
A. ROCKLIN DOMS, D.D.S.
SPECIALISTS IN ENDODONTICS

Acct. # _____

PATIENT REGISTRATION

Name _____

Sex: M F Social Security # _____ Date of Birth ____/____/____ Age _____

Home Address _____

City _____ State _____ Zip _____

Phone (home) _____ (work) _____

Spouse's or Parent's Name _____

In case of Emergency Contact _____

Phone # _____ Relationship _____

General Dentist _____

Employer Name _____

Occupation _____

Dental Insurance _____ Phone # _____ Group # _____

Insured's Name _____ D.O.B. _____ Social Sec. #_____ Employer _____

Second Dental Ins. _____ Phone # _____ Group # _____

Insured's Name _____ D.O.B. _____ Social Sec. #_____ Employer _____

HEALTH HISTORY

Please fill out completely and sign at bottom.

1. Do you have any CURRENT HEALTH PROBLEMS? ❑ Yes ❑ No
   If Yes, what? _____
2. Are you under a PHYSICIAN'S CARE now? ❑ Yes ❑ No
   If Yes, for what? _____
3. Are you currently taking any over the counter or prescription medication ❑ Yes ❑ No
   If Yes, what? _____
4. Do you have or have you had any of the following health conditions?

Yes	No		Yes	No	
❑	❑	Rheumatic Fever	❑	❑	Neurological Disorders
❑	❑	Mitral Valve Prolapse / Heart Murmur	❑	❑	Fainting / Dizzy Spells
❑	❑	Heart Disease / Attack / Surgery	❑	❑	Nervousness
❑	❑	Angina Pectoris	❑	❑	Trigeminal Neuralgia
❑	❑	Bacterial Endocarditis	❑	❑	Psychiatric Treatment
❑	❑	High / Low Blood Pressure	❑	❑	Diabetes
❑	❑	Congestive Heart Failure	❑	❑	Glaucoma
❑	❑	Asthma	❑	❑	Thyroid Problems
❑	❑	Tuberculosis (TB)	❑	❑	Liver Disease / Hepatitis
❑	❑	Sinus Trouble	❑	❑	Kidney Trouble
❑	❑	Anemia	❑	❑	Ulcers
❑	❑	Hemophilia / Bleeding Disorders	❑	❑	Arthritis
❑	❑	H.I.V.	❑	❑	Artificial Joints
❑	❑	Cancer	❑	❑	Jaw Joint problems
❑	❑	Epilepsy / Seizures	❑	❑	Cortisone / Steroid Medicine
			❑	❑	Drug / Alcohol Addiction

5. Have you ever taken?

Yes	No	
❑	❑	Fen-Phen or Other Weight Loss Drugs
❑	❑	Osteoperosis Drugs (i.e. Fosomax)

6. Women: Are you or could you be pregnant? Yes❑ No❑ If Yes, how far along?_____
7. Are you allergic or have you reacted adversely to any of the following:

Yes	No		Yes	No		Yes	No	
❑	❑	Aspirin	❑	❑	Erythromycin	❑	❑	Local Anesthetic (e.g. Novocaine)
❑	❑	Ibuprofen	❑	❑	Codeine	❑	❑	Latex Gloves / Material
❑	❑	Penicillin	❑	❑	Sulfa	❑	❑	Tetracycline

8. Are you aware of being allergic to any other medications or substances? If Yes, please list: _____

   _____
9. Is there any other Medical or Dental information that has not been mentioned above?_____

   _____

Medical Doctor: _____ Phone # _____

Patient Signature_____ Date_____

(I certify the above to be true & accurate)