Patient Registration and Medical History

(PLEASE PRINT)

Date_____ Home Phone_____ Cell Phone_____

Title: Dr. Mr. Mrs. Ms. Miss Sex: M F Age_____ Birthdate_____

Patient_____

Last Name **First Name** **Middle Initial** **Preferred Name**

Street Address_____ City_____ State_____ Zip_____

Employed by_____ Occupation_____

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 Company_____ Group #_____

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

Whom may we thank for referring you? _____

Medical History

Physician's Name_____ Physician's Phone #_____

Do you have or have you ever had any of the following? (Please check all boxes that apply)

❑ Heart Problems	❑ Stroke	❑ Allergy to Anesthetics	❑ Nervous problems
❑ High Blood Pressure	❑ Cancer	❑ General Allergies	❑ Psychiatric Care
❑ Heart Murmur	❑ Respiratory Disease	❑ Allergies to Medicine	❑ AIDS/other Immuno-Suppressive Disorders
❑ Circulatory Problems	❑ Hemophilia	❑ Latex Allergy	
❑ Rheumatic Fever	❑ Blood Disease	❑ Diabetes	❑ Headaches
❑ Radiation Treatment	❑ Hepatitis/Jaundice	❑ Thyroid Condition	❑ Sinus Problems
❑ Artificial Heart Valves	❑ Liver Disease	❑ Eating Disorders	❑ Back Problems
❑ Artificial Joints	❑ Epilepsy	❑ Gastric Reflux/GERD	❑ Swollen Neck Glands
❑ Mitral Valve Prolapse	❑ Ulcers	❑ Alcohol Dependency	❑ Osteoporosis
❑ Organ transplants	❑ Arthritis	❑ Chemical Dependency	❑ Xerostomia/Dry Mouth

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 medicine or dental treatment?_____

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

_____

Are you under the care of a physician?_____ For what condition?_____

Have you ever been told that you need to take antibiotics before any dental treatment? _____

Do you suspect that you are pregnant?_____ Are you nursing?_____

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

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing 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_____