PATIENT REGISTRATION AND MEDICAL HISTORY

Home Phone (____) ____________
Cell (____) ____________
Work (____) ____________
May we call you at work? ☐ Yes ☐ No

Date ____________

Patient ____
Last Name First Name Middle Preferred Name

Mailing Address ____________ City ____________ State ______ Zip ______
Street Address ____________ City ____________ State ______ Zip ______
Sex M F Age ______ Birthdate ____________ Email ____________
Employer ____________
Spouse ____________ Spouse Birthday ____________
Spouse Employed by ____________
Social Security # ____________ Spouse's Social Security # ____________
Name of Dental Insurance Company ____________ Group Number ____________
In case of emergency, who should be notified? ____________ Phone (____) ____________
Whom may we thank for referring you? ____________

MEDICAL HISTORY

Physician's Name ____________
Have you ever had any of the following?(check boxes that apply):

- ☐ Allergies
- ☐ Arthritis
- ☐ Artificial Heart Valves or Joints, Screws, etc.
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Cholesterol
- ☐ Chronic Diarrhea
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ High Blood Pressure
- ☐ HIV/AIDS or STD
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Swollen Neck Glands

Do you have any drug allergies or have you ever had an adverse reaction to any medications or anesthesia? ☐ Yes ☐ No
If so, what? ____________
Have you ever responded adversely to medical or dental treatment? ☐ Yes ☐ No
Are you taking any medication at this time? ______ If so, what? ____________
Are you under the care of a physician? ☐ Yes ☐ No For what conditions? ____________
(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Due Date ____________
(Women) Are you nursing? ☐ Yes ☐ No
Taking birth control pills? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No
Do you use chewing Tobacco? ☐ Yes ☐ No
Are your teeth bothering you? ☐ Yes ☐ No
Are you happy with the way your teeth look? ☐ Yes ☐ No
Is there anything we should know about your medical history? ____________

Patient Signature ____________