PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____

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

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? ☐ ☐ Are you happy with the way your teeth look? ☐ Yes ☐ No
Is there anything we should know about your medical history? _____

_____

_____

_____

Patient Signature _____