

PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ (PLEASE PRINT) Home Phone _____

Patient _____

Street Address _____ City _____ State _____ Zip _____

Sex () M () F Age _____ Birthdate _____

() Single () Married () Widowed () Separated () Divorced

Employed by _____ Occupation _____

Name of Dental Insurance Company _____ Group Number _____

Business Address _____ Business Phone _____

Spouse Name _____ Spouse Birthdate _____

Spouse Employed by _____ Occupation _____

Social Security # _____ Spouse's Social Security # _____

Name of Spouse's Dental Insurance Company _____ Group Number _____

Who is responsible for this account? _____ Relationship to Patient _____

In case of emergency who should be notified? _____ Phone _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Dentist's Name _____ Date of Last Cleaning _____

Have you ever had any of the following? (check boxes that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Special Diet |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Headaches | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Hepatitis, Jaundice, or Liver Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> A.I.D.S or other
Immunosuppressive Disorders |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Allergies to Anesthetics | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valves or Joints | <input type="checkbox"/> Allergies to Medicine or Drugs | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> General Allergies | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Psychiatric Care | |

Do you have any drug allergies or have ever had an adverse reaction to any medication? _____

If so, what _____

Have you ever responded adversely to medical or dental treatment? _____

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

Are you under the care of a physician? () Yes () No

For what condition? _____

(Women) Do you suspect that you are pregnant? () Yes () No Are you nursing? () Yes () No

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 of insurance for benefits, 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 have made in the completion of this form.

Date _____ Signature _____