

PATIENT REGISTRATION AND MEDICAL HISTORY

(Complete this form on your computer and Print)

Date \_\_\_\_\_ Home Phone \_\_\_\_\_

Patient \_\_\_\_\_  
 Last Name First Name Initial Preferred Name

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Spouse Name \_\_\_\_\_

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 Number \_\_\_\_\_

In case of emergency, who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of Last Physical \_\_\_\_\_

<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"/> Psychiatric Care	<input type="checkbox"/> "A I D S . " or Other immunosuppressive Disorders
<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Chronic Diarrhea	<input type="checkbox"/> Stroke
<input type="checkbox"/> Artificial Heart Valves or Joints	<input type="checkbox"/> Allergies to Anesthetics	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Allergies to Medicine or Drugs	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Back Problems	<input type="checkbox"/> General Allergies	<input type="checkbox"/> Chemical Dependency
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Respiratory Disease	<input type="checkbox"/> Arthritis	

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 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 conditions? \_\_\_\_\_

If patient is a child, what is his/her weight? \_\_\_\_\_

(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 for which I am entitled. I will not hold my dentist or any member of his/her stall responsible for any errors or omissions that I may have made in the completion of this form.

Date \_\_\_\_\_ Signature \_\_\_\_\_