Patient Registration and Medical History

Patient _____ Phone #_____

Street Address _____ City_____ State_____Zip_____

Sex [ ] M [ ] F Age____ Birthdate _____ [ ] Single [ ] Married [ ] Widowed [ ] Separated [ ] Divorced [ ] Student

Patient's Social Security #_____ Email Address_____Cell #_____

Employed by _____Occupation_____

Business Address _____ Business Phone_____

Spouse or Parent Name_____ Birthdate_____Relationship to Patient_____

Employed by _____ Business Address_____

Spouse or Parent Social Security #_____ Business Phone_____

Name of Insured _____ Insurance ID #_____ Group #_____

Name of Dental Insurance Company_____Address_____

Do You Have Additional Dental Insurance? If Yes, Please See Receptionist. Are you happy with your smile? [ ] Yes [ ] No

Whom may we thank for referring you?_____

MEDICAL HISTORY

Physician's Name_____ Date of Last Physical_____

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

[ ] Heart Murmur
[ ] Heart Problems
[ ] High Blood Pressure
[ ] Low Blood Pressure
[ ] Circulator Problems
[ ] Nervous Problems
[ ] Radiation Treatment
[ ] Artificial Heart Valves or Joints
[ ] Recent Weight Loss
[ ] Back Problems
[ ] Diabetes
[ ] Respiratory Disease
[ ] Do you take Aspirin, Plavix, Coumadin
[ ] Epilepsy
[ ] Headaches
[ ] Hepatitis, Jaundice or Liver Disease
[ ] Cancer_____
[ ] Psychiatric Care
[ ] Chronic Diarrhea
[ ] Allergies to Anesthetics
[ ] Allergies to Medicine or Drugs
[ ] General Allergies
[ ] Blood Disease
[ ] Arthritis
[ ] Special Diet
[ ] Swollen Neck Glands
[ ] Rheumatic Fever
[ ] Sinus Problems
[ ] "A.I.D.S." or Other Immunosuppressive Disorders
[ ] Stroke
[ ] Ulcer
[ ] Venereal Disease
[ ] Chemical Dependency
[ ] Hemophilia

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

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

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

Are you under the care of a physician? [ ] Yes [ ] No For what conditions? _____

If patient is a child, what is his/her weight?_____ Woman: Do you suspect that you are pregnant? [ ] Yes [ ] No Are you nursing?___

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

Person to contact in case of emergency _____ Phone_____

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 staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date_____

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ____________________

Are you taking any new medications?____________ If so, what? ____________________

____________ ____________________

Date Signature

____________ ____________________

Date Doctor's Signature

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ____________________

Are you taking any new medications?____________ If so, what? ____________________

____________ ____________________

Date Signature

____________ ____________________

Date Doctor's Signature

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ____________________

Are you taking any new medications?____________ If so, what? ____________________

____________ ____________________

Date Signature

____________ ____________________

Date Doctor's Signature

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ____________________

Are you taking any new medications?____________ If so, what? ____________________

____________ ____________________

Date Signature

____________ ____________________

Date Doctor's Signature