PATIENT REGISTRATION

Patient:______________________________ Cell Phone#:________________ Text?: Y or N

Street Address:________________________ City:______________ State:______ Zip:_______

Sex: [ ]M [ ]F Age:_____ Birthdate:__________ [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Student

Patient's Social Security #:____________ Email:________________ Other Phone #:_____________

Occupation:____________________ Employed by:______________________________

Spouse or Parent Name:________________ Birthdate:__________ Relationship to Patient:__________

Spouse or Parent Social Security #:______________________ Employed by:________________

Name of Insured:________________ Insurance ID #:______________ Group #:______________

Dental Insurance Company:________________ Address:___________________________

Do you have additional dental insurance? *If yes, 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 all boxes that apply):

[ ] Heart Murmur
[ ] Heart Problems
[ ] High Blood Pressure
[ ] Low Blood Pressure
[ ] Circulatory Problems
[ ] Nervous Problems
[ ] Radiation Treatment
[ ] Artificial Heart Valves
[ ] Artificial Joints__________
[ ] Recent Weight Loss
[ ] Back Problems
[ ] Diabetes
[ ] Respiratory Disease

[ ] Do you take Aspirin, Plavis, 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."
[ ] Immunosuppressive Disorders
[ ] Stroke________________
[ ] Ulcer
[ ] Venereal Disease
[ ] Chemical Dependency
[ ] Hemophilia
[ ] ____________________
[ ] ____________________
Do you smoke? [ ] Yes [ ] No

Do you take any medications?____

Do you pre-medicate before dental procedures?[ ] Yes [ ] No If so, with what? ______________

Do you have any drug allergies? If so, what?_______________________________________

Have you ever had an adverse reaction to any medication? If so, what?__________________

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

______________________________Any Recent Surgeries?_________________________

Children: What is his/her weight?_____ Women: Do you suspect that you are pregnant?_____ Are you nursing?_____

Person to contact in case of an emergency:________________ Relationship:_________ 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:________________