PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: __
Preferred Name: _____ Who referred you to us? _____
Patient Is: [ ] Policy Holder [ ] Responsible Party

Responsible Party (if someone other than the patient):
First Name: _____ Last Name: _____ Middle Initial: ___
Address: _____ Apt #: _____
City, State, Zip: _____
Home Phone: (___)_____ Work Phone: (___)_____ Cell Phone: (___)_____
Email Address: _____@_____
Birth Date: __/__/__ SS#: _____-____-_____
[ ] Responsible Party is also a Policy Holder for Patient
[ ] Primary Ins. Policy Holder OR [ ] Secondary Ins Policy Holder

Patient Information:
First Name: _____ Last Name: _____ Middle Initial: ___
Address: _____ Apt #: _____
City, State, Zip: _____
Home Phone: (___)_____ Work Phone: (___)_____ Cell Phone: (___)_____
Email Address: _____@_____
Birth Date: __/__/__ SS#: _____-____-_____
Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed
Student Status: [ ] Full Time [ ] Part Time
Employment Status: [ ] Full Time [ ] Part Time [ ] Retired
What is the **Best Way** to Contact you?
[ ] Home Phone [ ] Work Phone [ ] Cell Phone([ ] Text Message) [ ] Email
[ ] Facebook [ ]Other method: _____

Primary Insurance Information:
Name of Insured: _____ Birth Date: __/__/__ SS#: ___-___-____
Relationship to Insured: [ ] Self [ ] Spouse [ ] Child [ ] Other _____
Employer: _____ Ins. Company: _____
Address: _____ Address: _____
City, State, Zip: _____ City, State, Zip: _____

Secondary Insurance Information:
Name of Insured: _____ Birth Date: __/__/__ SS#: ___-___-____
Relationship to Insured: [ ] Self [ ] Spouse [ ] Child [ ] Other _____
Employer: _____ Ins. Company: _____
Address: _____ Address: _____
City, State, Zip: _____ City, State, Zip: _____

Medical History

Patient Name: _____ Birth Date: ____/____/_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with dentistry you will receive. Thank you for answering the following questions.

Are you under a physcian's care now? [ ] Yes [ ] No

If yes please explain: _____

Have you ever been hospitalized or had a major operation? [ ] Yes [ ] No

If yes please explain: _____

Have you ever had a serious head or neck injury? [ ] Yes [ ] No

If yes please explain: _____

Are you taking any medications, pills, or drugs? [ ] Yes [ ] No

If yes please list: _____

Do you premedicate with antibiotics for dental visits? [ ] Yes [ ] No

Do you take or have you taken, Phen-Fen or Redux? [ ] Yes [ ] No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphanates? [ ] Yes [ ] No

Do you take aspirin daily? [ ] Yes [ ] No

Do you use controlled substances? [ ] Yes [ ] No

Women: Are you

Pregnant/Trying to get pregnant? [ ] Yes [ ] No Taking oral contraceptives? [ ] Yes [ ] No Nursing? [ ] Yes [ ] No

Are you allergic to any of the following?

[ ] Asprin [ ] Penicillin [ ] Latex [ ] Codeine [ ] Local Anesthetics [ ] Acrylic [ ] Metal [ ] Sulfa Drugs

[ ] Other – Please list: _____ No Known Allergies [ ]

Do you have, or have you had, any of the following:

[ ] Yes [ ] No AIDS/HIV Positive	[ ] Yes [ ] No Cortisone Medicine	[ ] Yes [ ] No Hemophilia	[ ] Yes [ ] No Radiation Treatments
[ ] Yes [ ] No Alzheimer's Disease	[ ] Yes [ ] No Diabetes	[ ] Yes [ ] No Hepatitis A	[ ] Yes [ ] No Recent Weight Loss
[ ] Yes [ ] No Anaphylaxis	[ ] Yes [ ] No Drug Addiction	[ ] Yes [ ] No Hepatitis B or C	[ ] Yes [ ] No Renal Dialysis
[ ] Yes [ ] No Anemia	[ ] Yes [ ] No Easily Winded	[ ] Yes [ ] No Herpes	[ ] Yes [ ] No Rheumatic Fever
[ ] Yes [ ] No Angina	[ ] Yes [ ] No Emphysema	[ ] Yes [ ] No High Blood Pressure	[ ] Yes [ ] No Rheumatism
[ ] Yes [ ] No Arthritis/Gout	[ ] Yes [ ] No Epilepsy or Seizures	[ ] Yes [ ] No High Cholesterol	[ ] Yes [ ] No Scarlet Fever
[ ] Yes [ ] No Artificial Heart Valve	[ ] Yes [ ] No Excessive Bleeding	[ ] Yes [ ] No Hives or Rash	[ ] Yes [ ] No Shingles
[ ] Yes [ ] No Artificial Joint	[ ] Yes [ ] No Excessive Thirst	[ ] Yes [ ] No Hypoglycemia	[ ] Yes [ ] No Sickle Cell Disease
[ ] Yes [ ] No Asthma	[ ] Yes [ ] No Fainting Spells	[ ] Yes [ ] No Irregular Heartbeat	[ ] Yes [ ] No Sinus Trouble
[ ] Yes [ ] No Blood Disease	[ ] Yes [ ] No Frequent Cough	[ ] Yes [ ] No Kidney Problems	[ ] Yes [ ] No Spina Bifida
[ ] Yes [ ] No Blood Transfusion	[ ] Yes [ ] No Frequent Diarrhea	[ ] Yes [ ] No Leukemia	[ ] Yes [ ] No Stomach/Intestinal Disease
[ ] Yes [ ] No Breathing Problem	[ ] Yes [ ] No Frequent Headaches	[ ] Yes [ ] No Liver Disease	[ ] Yes [ ] No Stroke
[ ] Yes [ ] No Bruise Easily	[ ] Yes [ ] No Genital Herpes	[ ] Yes [ ] No Low Blood Pressure	[ ] Yes [ ] No Swelling of Limbs
[ ] Yes [ ] No Cancer	[ ] Yes [ ] No Glaucoma	[ ] Yes [ ] No Lung Disease	[ ] Yes [ ] No Thyroid Disease
[ ] Yes [ ] No Chemotherapy	[ ] Yes [ ] No Hay Fever	[ ] Yes [ ] No Mitral Valve Prolapse	[ ] Yes [ ] No Tonsillitis
[ ] Yes [ ] No Chest Pains	[ ] Yes [ ] No Heart Attack/Failure	[ ] Yes [ ] No Osteoporosis	[ ] Yes [ ] No Tuberculosis
[ ]Yes [ ]No Cold Sores/Fever Blisters	[ ] Yes [ ] No Heart Murmur	[ ] Yes [ ] No Pain in Jaw Joints	[ ] Yes [ ] No Tumors or Growths
[ ]Yes [ ]No Congenital Heart Disease	[ ] Yes [ ] No Heart Pacemaker	[ ] Yes [ ] No Parathyroid Disease	[ ] Yes [ ] No Venereal Disease
[ ] Yes [ ] No Convulsions	[ ] Yes [ ] No Heart Trouble/Disease	[ ] Yes [ ] No Psychiatric Care	[ ] Yes [ ] No Yellow Jaundice

Have you ever had any serious illness not listed above? [ ] Yes [ ] No _____

Comments: _____

To the Best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or Patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____ Date: ____/____/_____