PATIENT REGISTRATION

***Whom may we thank for referring you?*___________________________________**

May appointments be scheduled by e-mail? Y N Add:_____________________
May appointment reminders be sent via text message? Y N #:_____________

Patient name:____
First M.I. Last
Preferred name:___________________ Sex: ___M ___F

Address:____
____

Home Phone:_________________ Date of birth:___________________
Work Phone:_________________ Soc. Sec.________________________
Cell Phone:__________________ Drivers Lic.____________________

Marital Status: __Single __Married __Divorced __Widowed

Responsible Party (if other than patient)
Name:____
First M.I. Last
Address (if different from patient):
____
Home Phone:________________ Date of birth:________________
Work Phone:________________ Soc. Sec.____________________
Cell Phone:_________________ Drivers Lic:__________________

Insurance Information
Name of insured:__________________ Relationship to patient:________________
Insured Soc. Sec._________________ Insured birth date:_____________________
Employer:_______________________ Insurance Co:________________________
Address:________________________ Address:____________________________
_______________________ ____________________________
Phone:_________________________ Phone:_____________________________

Miscellaneous Information
Previous dentist:__________________ Date of last dental visit:_________________
Date of most recent dental x-rays: _________
Preferred pharmacy:________________
Emergency contact:_____________________ Contact #:______________________

MEDICAL HISTORY

PATIENT NAME____ BIRTH DATE_________________

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

Are you under a physician'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 explain: ____
____
Do you take, or have you taken Phen-Fen or Redux? Yes No ____
Are you on a special diet? Yes No ____
Do you use tobacco? 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:
___Aspirin ___Penicillin ___Codeine ___Acrylic ___Metal ___Latex ___Local anesthetics
___Other If yes, please explain:____

Do you have, or have you had any of the following (please circle):

AIDS/HIV **+**	Cortisone Medicine	Hemophilia	Renal Dialysis
Alzheimer's Disease	Diabetes	Hepatitis A	Rheumatic Fever
Anaphylaxis	Drug Addiction	Hepatitis B or C	Rheumatism
Anemia	Easily Winded	Herpes	Scarlet Fever
Angina	Emphysema	High Blood Pressure	Shingles
Arthritis/Gout	Epilepsy or Seizures	Hives or Rash	Sickle Cell Disease
Artificial Heart Valve	Excessive Bleeding	Hypoglycemia	Sinus Trouble
Artificial Joint	Excessive Thirst	Irregular Heartbeat	Spina Bifida
Asthma	Fainting Spells/Dizziness	Kidney Problems	Stomach/Intestinal Disease
Blood Disease	Frequent Cough	Leukemia	Stroke
Blood Transfusion	Frequent Diarrhea	Liver Disease	Swelling of limbs
Breathing Problem	Frequent Headaches	Low Blood Pressure	Thyroid Disease
Bruise Easily	Genital Herpes	Lung Disease	Tonsilitis
Cancer	Glaucoma	Mitral Valve Prolapse	Tuberculosis
Chemotherapy	Hay Fever	Pain in Jaw Joints	Tumors or Growths
Chest Pains	Heart Attack/Failure	Parathyroid Disease	Ulcers
Cold sores/Fever blisters	Heart murmur	Psychiatric Care	Venereal Disease
Congenital Heart Disorder	Heart Pace Maker	Radiation Treatments	Yellow Jaundice
Convulsions	Heart Trouble/Disease	Recent Weight Loss	

Have you ever had any serious illness not listed above? Y N If yes, please explain:____
____

Additional 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:____________________________