PATIENT REGISTRATION FORM

Patient's First_____MI_____Last_____ Date of Birth_____

Responsible Party_____ Policy Holder Name_____

Address_____

Home Phone #_____ Cell Phone #_____

Sex M or F Social Security #_____ Driver's License #_____

Email Address_____

Marital Status Single Married Divorced Separated Widowed Spouse Name_____

Employer_____ Occupation_____

Work Phone #_____

In Case of Emergency, call_____ Phone #_____Relationship_____

How did you hear about our office?_____

Previous Dental Office_____

PARENT/GUARDIAN INFORMATION

Name_____ Date of Birth_____

Address (if different from above)_____

Home Phone #_____ Cell Phone #_____ SSN_____

Employer_____ Occupation_____

Work Phone #_____

IF YOU HAVE DENTAL COVERAGE, PLEASE BRING YOUR INSURANCE CARD ON YOUR APPT. DATE.

MEDICAL HISTORY

Are you under a physician's care now? Yes/No Explain_____

Physician's Name and Location_____

Have you ever been hospitalized or had a major operation? Yes/No Explain_____

Have you ever had a serious head/neck injury? Yes/No Explain_____

Are you taking any medications, vitamins, supplements? List _____

_____

Do you use tobacco? Yes/No Type_____ Quantity_____

Do you take any controlled substances? Yes/No Type_____

Have you ever taken Phen-Fen, Redux, Foximax or Zometa? Yes/No

Are you pregnant? Yes/No Breastfeeding? Yes/No Taking oral contraceptives? Yes/No

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other Antibiotics Other_____

Have you been told to take an antibiotic prior to your dental treatment? Yes/No _____

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

	Y	N		Y	N		Y	N		Y	N
AIDS/HIV			Cortisone Medicine			Hemophilia			Renal Dialysis		
Alzheimer's Disease			Diabetes			Hepatitis A			Rheumatic Fever		
Anaphylaxis			Drug Addiction						Rheumatism		
Anemia			Easily Winded			Herpes			Scarlet Fever		
Angina			Emphysema			High Blood Pressure			Shingles		
Arthritis/Gout			Epilepsy/Seizures			Hives/Rash			Sickle Cell Disease		
Artificial Heart Valve			Excessive Bleeding			Hypoglycemia			Sinus Trouble		
Artificial Joint			Excessive Thirst			Irregular Heartbeat			Spina Bifida		
Asthma			Fainting/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			Tonsillitis		
Cancer			Glaucoma			Mitral Valve Prolapse			Tuberculosis		
Chemotherapy			Hay Fever			Pain in Jaw Joints			Tumors/Growths		
Chest Pains			Heart Attack/Failure			Parathyroid Disease			Ulcers		
Cold Sores			Heart Murmur			Psychiatric Care			Venereal Disease		
Congenital Heart Disorder			Heart Pace Maker			Radiation Treatment			Yellow Jaundice		
Convulsions			Heart Disease			Recent Weight Loss					

Do you have any condition or disease not mentioned above? Yes/No

Comments_____

Printed Name_____Signature_____Date_____