

## PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION:

Name	Date
If patient is a minor, please provide parent's names:	
Address	
City	State                      Zip
Home Phone	Cell Phone
Your SSN#	B-Day                      Email:
Marital Status	Spouse's Name

### YOUR:

Employer	Occupation
Bus. Address	City                      State                      Zip
Bus. Phone	Length of Employment

### YOUR SPOUSE

Employer	Occupation
Bus. Phone	Length of Employment

### GETTING TO KNOW YOU:

ARE ANY RELATIVES PATIENTS IN OUR OFFICE?	
Their names:	
Whom may we thank for your referral?	
Person to contact in case of emergency?	
Name	Phone
Person financially responsible for account	
Last dental visit	

DENTAL INSURANCE

YES

NO

Carrier (PRIMARY)
Insurance Co.
Group No.
Policy No.
Employee SSN#
Date Employed

# MEDICAL HISTORY

1. Date of your last physical examination: \_\_\_\_\_

2. Have you been hospitalized or had a serious illness within the last 3 years? Yes No

If so, please describe \_\_\_\_\_

3. Are you under the care of physician: Yes No

If so, for what condition? \_\_\_\_\_

Doctor's name and phone#: \_\_\_\_\_

4. Please circle any of the following which you have had or now have:

- |                               |                           |                          |
|-------------------------------|---------------------------|--------------------------|
| Heart Failure                 | Emphysema                 | A.I.D.S.                 |
| Heart Disease or Attack       | Cough                     | Hepatitis A (infectious) |
| Angina Pectoris               | Tuberculosis              | Hepatitis B (serum)      |
| High Blood Pressure           | Asthma                    | Liver Disease            |
| Heart Murmur                  | Hay Fever                 | Yellow Juandice          |
| Rheumatic Fever               | Sinus Trouble             | Blood Transfusion        |
| Congenital Heart Lesions      | Allergies or Hives        | Drug Addiction           |
| Scarlet Fever                 | Diabetes                  | Hemophilia               |
| Artificial Heart Valve        | Thyroid Disease           | Venereal Disease         |
| Heart Pacemaker               | X-ray or Cobalt Treatment | Cold Sores               |
| Heart Surgery                 | Chemotherapy              | Fever Blisters           |
| Artificial Joints (hip, knee) | Arthritis                 | Epilepsy or Seizures     |
| Anemia                        | Rheumatism                | Fainting or Dizzy Spells |
| Stroke                        | Cortisone Medicine        | Nervousness              |
| Kidney Trouble                | Glaucoma                  | Psychiatric Treatment    |
| Ulcers                        | Pain in Jaw Joints        | Sickle Cell Disease      |

5. Have you ever been told you need antibiotics before dental treatment? Yes No

6. Are you taking any medications at this time? Yes No

(antibiotics, anticoagulants, steroid, tranquilizers, HBP med, aspirin, BC pill, etc.)

If so, Drug: \_\_\_\_\_ Amount: \_\_\_\_\_ How often? \_\_\_\_\_

Drug: \_\_\_\_\_ Amount: \_\_\_\_\_ How often? \_\_\_\_\_

7. Do you have any allergies or reactions to any drugs or medications? Yes No

(novacaine, penicillin, other antibiotics, sulfa drugs, aspirin, barbiturates, etc.)

If so, Drug: \_\_\_\_\_ Reaction: \_\_\_\_\_

Drug: \_\_\_\_\_ Reaction: \_\_\_\_\_

8. Do you use a tobacco product? Yes No If so, what type? \_\_\_\_\_

9. Please list any problem or condition not listed above: \_\_\_\_\_

**FOR WOMEN ONLY:** Are you pregnant? Yes No scheduled delivery: \_\_\_\_\_

\_\_\_\_\_  
PATIENT'S SIGNATURE

\_\_\_\_\_  
DATE