REGISTRATION/HISTORY

Date_____

Patient's Name_____ Male____ Female_____ Single_____
Married_____
Name of Spouse_____ Widowed_____
Divorced_____
If a Minor, Parent's Name_____ Separated_____

Street Address_____Phone_____

City_____ State_____ Zip Code_____

Patient Employed by_____Occupation_____

Business Address_____ Phone_____

Spouse Employed by_____Occupation_____

Business Address_____ Phone_____

Purpose of this appointment_____

In case of Emergency, who should be notified? _____ Phone_____

Who will pay this account?_____ Relationship to patient_____

Social Security Number_____Birth date_____

Spouse's Social Security Number_____Birth date_____

Who may we thank for referring you?_____

Payment is due in full at the time of treatment.

Insurance Information

Do you have insurance that may cover any part of our professional services? Yes____ No____

Primary insurance _____Policy No._____

Name of policy holder_____ Social Security No._____

Policy holder's date of birth_____

Policy holder's employer_____

Do you have other insurance? Yes____ No____

If yes, name of secondary insurance co. _____Policy No._____

Name of policy holder_____ Social Security No._____

Policy holder's date of birth_____

Policy holder's employer_____

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain your oral health in the best condition possible. Please fill out this form completely. The more we communicate, the better we can care for you.

PLEASE SEE OTHER SIDE

Date of last medical examination _____ Patient's date of birth _____ Current age_____

Have you been hospitalized in the last 5 years?_____ If so, for what?_____

Have you ever had any of the following diseases or medical problems?

Y N Heart Attack
Y N Stroke
Y N Cancer
Y N Chemotherapy
Y N Heart Murmur
Y N Rheumatic Fever
Y N HIV/AIDS
Y N Heart Surgery
Y N Pacemaker
Y N Shingles
Y N Mitral Valve Prolapse
Y N Kidney Problems
Y N Artificial Bones/Joints
Y N Artificial Valves
Y N Sinus Problems
Y N High Blood Pressure
Y N Low Blood Pressure
Y N Fever Blisters
Y N Severe/Frequent Headaches
Y N Emphysema

Y N Psychiatric Problems
Y N Epilepsy
Y N Seizures
Y N Fainting Spells
Y N Diabetes
Y N Tuberculosis
Y N Drug/Alcohol Abuse
Y N Venereal Disease
Y N Hemophilia/Abnormal Bleeding
Y N Ulcers
Y N Colitis
Y N Congenital Heart Defect
Y N Anemia
Y N Radiation Treatment
Y N Asthma
Y N Arthritis
Y N Difficulty Breathing
Y N Hepatitis
Y N Blood Transfusion
Y N Glaucoma

Are you allergic to any of the following drugs?

Y N Penicillin
Y N Aspirin
Y N Erythromycin

Y N Tetracycline
Y N Dental Anesthetics
Y N Codeine

Y N Latex
Y N Other

Please list any other drugs that you are allergic to_____

Are you taking any medication now? _____

Please list any medications and the reason for their use.

Medication	Purpose

Other physical conditions we should be aware of_____

Name of your physician_____ Phone No._____

Are you receiving care now?_____ If so, for what_____

May we request your health records? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status.

Signed:_____ Date:_____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.