PATIENT REGISTRATION AND MEDICAL HISTORY

Please Use Black Ink (PLEASE PRINT)

E-Mail _____

Cell # _____

Date: _____ Home Phone: _____

Patient: _____
Last Name First Name Initial Preferred Name

Street Address _____ City _____ State _____ Zip _____

Sex: ☐ M ☐ F Age___ Birthdate _____ SS#: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Name of Spouse: _____ Occupation: _____ Business Phone: _____

Whom can we thank for referring you: ☐ Insurance Co. ☐ Advertisement ☐ One of our existing Patients (please provide name:)_____

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

INSURANCE INFORMATION

Subscriber: _____ Relationship to Patient:_____ Subscriber's Date of Birth: _____

Subscriber's SS#: _____ Employer: _____

Subscriber's Address: _____ City _____ State _____ Zip _____

Dental Insurance Co: _____ Telephone # for Dental Insurance Co: _____ Group #: _____

Secondary Dental Insurance Co: _____ Telephone # for Secondary Insc Co: _____ Group #: _____

MEDICAL HISTORY

Physician's Name: _____ Physician's Phone #: _____ Date of Last Physical: _____

Have you ever had any of the following ? (check yes or no)

Yes	No		Yes	No		Yes	No	
()	()	Heart Problems	()	()	Epilepsy	()	()	Special Diet
()	()	High Blood Pressure	()	()	Headaches	()	()	Swollen Neck Glands
()	()	Low Blood Pressure	()	()	Hepatitis, Jaundice or Liver Disease	()	()	Rheumatic Fever
()	()	Circulatory Problems	()	()	Cancer	()	()	Sinus Problems
()	()	Nervous Problems	()	()	Psychiatric Care	()	()	"A.I.D.S." or other
()	()	Radiation Treatment	()	()	Chronic Diarrhea	()	()	Immunosuppressive cond.
()	()	Artificial Heart Valves or Joints	()	()	Allergies to Anesthetics	()	()	Stroke
()	()	Recent Weight Loss	()	()	Allergies to Medicine or Drugs	()	()	Ulcer
()	()	Back Problems	()	()	General Allergies	()	()	Venereal Disease
()	()	Diabetes	()	()	Blood Disease	()	()	Chemical Dependency
()	()	Respiratory Disease	()	()	Arthritis	()	()	Hemophilia
			()	()	Osteoporosis	() Other _____		

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____ If so, what _____

Have you ever responded adversely to medical or dental treatment? _____ If so, how _____

Are you taking any medication at this time? _____ If so, please indicate name: _____

Are you under the care of a physician? _____ If so, for what conditions: _____

If patient is a child, what is his/her weight? _____

(Women) Do you suspect you are/may be pregnant? ☐ Yes ☐ No If yes, how many months? _____/ Are you nursing? ☐ Yes ☐ No

Are you allergic to Latex Gloves? ☐ Yes ☐ No

Have you ever taken any Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Is there anything we should know about your medical history? _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits to which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ Signature: _____

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?________________________________

Are you taking any new medications?__________ If so, what________________________

______________ ______________________________
Date *Signature*

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?________________________________

Are you taking any new medications?__________ If so, what________________________

______________ ______________________________
Date *Signature*

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?________________________________

Are you taking any new medications?__________ If so, what________________________

______________ ______________________________
Date *Signature*

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?________________________________

Are you taking any new medications?__________ If so, what________________________

______________ ______________________________
Date *Signature*

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?________________________________

Are you taking any new medications?__________ If so, what________________________

______________ ______________________________
Date *Signature*