PATIENT REGISTRATION AND MEDICAL HISTORY

Date ____________________________ (PLEASE PRINT) Home Phone ____________________________

Cell Phone ____________________________

Patient ____
Last Name First Name Initial Preferred Name

Street Address ______________________________ City ______________ State ______________ Zip ______________

Sex: ☐ M ☐ F Age __________ Birthdate ______________ SS# ____________________________ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employed by ____________________________ Phone # ______________ or student at ____________________________

Spouse Name ____________________________ Spouse Birthdate ____________ Spouse Social Security # ______________________

Spouse Employed by ____ Business Phone ____________________________

Who is responsible for this account? ______________________________ Relationship to Patient ______________________

Responsible Party Address ______________________________ SS# __________________ Birthdate ______________

Primary Dental Ins. Co. ______________________________ Group # __________________ Employee ID# ______________

2nd Dental Insurance Company ______________________________ Group # __________________ Employee ID# ______________

In case of emergency, who should be notified? ______________________________ Phone ______________________

Whom may we thank for referring you? ______________________________ Previous Dentist: ______________________

MEDICAL HISTORY

Date of last Dental Visit: ______________________

Physician's Name: ______________________________ Date of Last Physical: ______________________

Have you ever had any of the following? (check the boxes that apply):

- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Artificial Heart Valves or Joints
- ☐ Recent Weight Loss
- ☐ Back Problems
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Acid Reflux
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Cancer
- ☐ Psychiatric Care
- ☐ Chronic Diarrhea
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ General Allergies
- ☐ Blood Disease
- ☐ Arthritis
- ☐ Thyroid Disease
- ☐ Special Diet
- ☐ Sleep Apnea
- ☐ Swollen Neck Glands
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ "A.I.D.S." or Other Immunosuppressive Disorders
- ☐ Stroke
- ☐ Sexually Transmitted Disease
- ☐ Chemical Dependency
- ☐ Hemophilia
- ☐ Tobacco Use

Do you have any drug allergies or have you ever had an adverse reaction to any medication? ☐ Yes ☐ No If yes, please list ____________________

____

Are you taking any medication at this time? ☐ Yes ☐ No If yes, please list ______________________________

____

Do you take a premed prior to having dental work? ☐ Yes ☐ No ☐ Unsure If yes, please explain ______________________

____

Do you or have you taken bisphosphonate drugs (i.e. Fosamax, Alendronate) for osteoporosis or cancer treatment? ☐ Yes ☐ No ☐ Unsure

If yes, please explain ____

Is there anything you would change about your smile? ☐ Yes ☐ No If yes, please explain ______________________

____

Do you snore? ☐ Yes ☐ No Do you wear a C-Pap? ☐ Yes ☐ No Have you had a sleep study? ☐ Yes ☐ No

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

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

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 for 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 or any surgeries since your last dental appointment ☐ Yes ☐ No If yes, please list_________________

____

Has there been any change in your medications since your last dental appointment? ☐ Yes ☐ No If yes, please list_________________________

____

_____________________________ ____

Date *Signature*

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_____________________________ ____

Date *Signature*

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Date *Signature*

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Date *Signature*

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Date *Signature*