PATIENT REGISTRATION AND MEDICAL HISTORY

DATE: ______ **HOME PHONE:** ______ CELL PHONE ______

NAME ______ PREFERRED NAME: ______

BIRTHDATE: ______ AGE ______ SEX: ______ MARITAL STATUS: ______

BILLING ADDRESS: ______

HOUSE ADDRESS (IF DIFFERENT) ______

EMPLOYED BY ______ OCCUPATION ______

BUSINESS ADDRESS ______ BUSINESS PHONE ______

EMAIL ADDRESS ______

SPOUSE/PARTNER NAME ______ SPOUSE/PARTNER'S OCCUPATION: ______

SPOUSE/PARTNER'S WORK PHONE NUMBER ______ SPOUSE/PARTNER'S BUSINESS ADDRESS ______

(IF A Child) PARENT/GUARDIAN NAME: ______ PHONE NUMBER (If Different) ______

WHO IS RESPONSIBLE FOR THIS ACCOUNT (OTHER THEN YOUR INSURANCE COMPANY)? ______

INSURANCE COMPANY ______ GROUP NUMBER ______

SOCIAL SECURITY NUMBER ______ SPOUSE/PARTNER'S SOCIAL SECURITY NUMBER ______

PARENT/GUARDIAN SOCIAL SECURITY NUMBER ______ SPOUSE/PARTNER/PARENT'S BIRTHDATE ______

EMERGENCY CONTACT ______ PHONE NUMBER: ______

DO WE HAVE YOUR PERMISSION TO DISCUSS ANY ASPECT OF YOUR DENTAL TREATMENT WITH YOUR SPOUSE/PARTNER? ______

MEDICAL HISTORY

PHYSICIAN'S NAME ______ DATE OF LAST PHYSICAL ______ DOCTOR'S PHONE # ______

Have you ever had any of the following? (check 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
- ☐ 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
- ☐ Special Diet
- ☐ Swollen Neck Glands
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ "A.I.D.S." or Other Immunosuppressive Disorders
- ☐ Stroke
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Hemophilia

-Mitral Valve Prolapse

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? ______

ARE YOU UNDER THE CARE OF A PHYSICIAN AT THIS TIME? Y N

FOR WHAT CONDITIONS? ______

(over)

PATIENT REGISTRATION AND MEDICAL HISTORY

ARE YOU TAKING ANY MEDICATION AT THIS TIME?__________ IF SO, WHAT?__________

____

HAVE YOU EVER BEEN OR DO YOU NEED TO BE PREMEDICATED FOR YOUR DENTAL APPOINTMENTS?__________

ARE YOU ON ANY HERBAL SUPPLEMENTS? IF SO, WHAT?__________

(Women) ARE YOU ON BIRTH CONTROL?__________ DO YOU SUSPECT YOU ARE PREGNANT?__________

ARE YOU NURSING?__________

DO YOU SMOKE?__________ DO YOU CHEW SMOKELESS TOBACCO?__________

IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOU MEDICAL HISTORY?

____

____

IS THERE ANYTHING WE SHOULD KNOW ABOUT YOU DENTAL HISTORY?

____

____

____

____

IS THERE ANYTHING YOU WOULD LIKE TO CHANGE ABOUT YOUR SMILE?

____

____

HAVE YOU EVER BEEN INTERESTED IN COSMETIC DENTISTRY?__________

____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE?__________

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 understand that my signature on this form allows my dentist to file my dental claims electronically. I know my medical health history and personal information will not be shared with any outside party unless it involves my being referred to another doctor or dentist and the information on this form is judged pertinent to my treatment. 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 __________