PATIENT REGISTRATION FORM

Patient information

Name: _____ Email: _____
Last First Middle

Address: _____ City: _____ State: _____ Zip: _____
(P.O. box addresses are not acceptable)

DOB: _____ SS#: _____ DL#: _____ State issued: _____

Phone Home: _____ Work: _____ Cell: _____ **Sex:** M F **Marital Status:** M S D W

Employment: Full Time Part Time Retired **Student:** Full Time Part Time

Employer Name: _____ Employer Phone: _____ Address: _____

Insurance or Employee ID: _____

Responsible party information

Name: _____ Email: _____
Last First Middle

Address: _____ City: _____ State: _____ Zip: _____
(P.O. box addresses are not acceptable)

DOB: _____ SS#: _____ DL#: _____ State issued: _____

Phone Home: _____ Work: _____ Cell: _____ **Sex:** M F **Marital Status:** M S D W

Primary Insurance Information

Name of Insured: _____ Relationship to Insured (Circle One): Self Spouse Child Other

Insured Social Security Number: _____ Insured Date of Birth: _____

Insurance Company: _____ Address: _____ Insurance Phone: _____

Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured (Circle One): Self Spouse Child Other

Insured Social Security Number: _____ Insured Date of Birth: _____

Insurance Company: _____ Address: _____ Insurance Phone: _____

Rem. Benefits: _____ Rem. Deduct: _____

Emergency Contact: _____ **Phone:** _____

Relationship to Patient: _____

MEDICAL HISTORY

AIDS / HIV Positive	Y N	Diabetes	Y N	Hepatitis A	Y N	Rheumatic Fever	Y N	Alzheimer's Disease	Y N
Drug Addiction	Y N	Hepatitis B or C	Y N	Rheumatism	Y N	Anemia	Y N	Easily Winded	Y N
Herpes	Y N	Scarlet Fever	Y N	Angina	Y N	Emphysema	Y N	High Blood Pressure	Y N
Shingles	Y N	Arthritis/ Gout	Y N	Epilepsy or Seizures	Y N	Hives or Rash	Y N	Sickle Cell Disease	Y N
Artificial Heart Valve	Y N	Excessive Bleeding	Y N	Hypoglycemia	Y N	Sinus Trouble	Y N	Artificial Joint	Y N
Excessive Thirst	Y N	Irregular Heart Beat	Y N	Spinal Bifida	Y N	Asthma	Y N	Fainting/ Dizzy spells	Y N
Kidney Problems	Y N	G.I. Disease	Y N	Blood Disease	Y N	Frequent Cough	Y N	Leukemia	Y N
Stroke	Y N	Blood Transfusion	Y N	Frequent Headaches	Y N	Low Blood Pressure	Y N	Thyroid Disease	Y N
Breathing Problems	Y N	Frequent Diarrhea	Y N	Liver Disease	Y N	Swelling of the Limbs	Y N	Bruise Easily	Y N
Genital Herpes	Y N	Lung Disease	Y N	Tonsillitis	Y N	Cancer	Y N	Glaucoma	Y N
Mitral Valve Prolapse	Y N	Tuberculosis	Y N	Chemotherapy	Y N	Hay Fever	Y N	Pain in Jaw Joints	Y N
Tumors or Growths	Y N	Chest Pains	Y N	Heart attack	Y N	Parathyroid Disease	Y N	Ulcers	Y N
Cold Sores	Y N	Heart Murmur	Y N	Psychiatric Care	Y N	Venereal Disease	Y N	Congenital Heart Disorder	Y N
Heart Pace Maker	Y N	Radiation Treatment	Y N	Yellow Jaundice	Y N	Convulsions	Y N	Heart Trouble	Y N
Recent Weight Loss	Y N	Cortisone Medicine	Y N	Hemophilia	Y N	Retinal Dialysis	Y N		

Have you ever had any serious illness not listed above? Y N **If yes, please explain:** _____

Are you allergic to any of the following? Aspirin / Penicillin / Codeine / Acrylic / Metal / Latex / Local Anesthetics / Any other Allergies ? _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now, or have been in the past 2 years? Yes No If yes, please explain: _____

Name of Physician: _____ **Phone Number:** _____

Have you been hospitalized or had a major operation in the past 5 years? Yes No **If yes, please explain:** _____

Have you ever had a serious head or neck injury? Yes No **If yes, please explain:** _____

Are you currently taking any medications, pills or drugs? Yes No **If yes, please explain:** _____

Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	Are you on a Special Diet?	Yes	No
Do you use tobacco?	Yes	No	Do you use controlled substance?	Yes	No
Women: Are you pregnant / trying to get pregnant?	Yes	No	Women: Taking oral contraceptives?	Yes	No
Women: Nursing?	Yes	No			

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in the condition of my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

Comments: _____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ **DATE** _____