PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ (PLEASE PRINT) Home Phone _____

Patient _____ SS# _____
Last Name First Name, Initial

Street Address _____ City _____ State _____ Zip _____

E-mail Address: _____

Sex: ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Father or Spouse Name (circle one) _____ SS# _____

Employed By _____ Occupation _____ Date of Birth _____

Business Address _____ Business Phone _____

Mother's Name (if minor) _____ SS# _____

Employed By _____ Occupation _____ Date of Birth _____

Business Address _____ Business Phone _____

Name of Dental Insurance Company _____ Group Number _____

In case of emergency. who should be notified? _____ Phone # _____

How did you hear about our office? _____

MEDICAL HISTORY

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

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

- ☐ Mitral Valve Prolapse
- ☐ Heart Problems
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Heart Stents
- ☐ Blood Thinners
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Nervous Problems
- ☐ Radiation Treatment/Chemotherapy
- ☐ Artificial Heart Valves or Joints
- ☐ Recent Weight Loss
- ☐ Back Problems
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Surgery for any reason
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Cancer
- ☐ Psychiatric Care
- ☐ Chronic Diarrhea
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ General Allergies
- ☐ Dialysis
- ☐ Arthritis
- ☐ Excessive Bleeding
- ☐ Special Diet
- ☐ Swollen Neck Glands
- ☐ Sinus Problems
- ☐ "A.I.D.S." or Other
- ☐ Immunosuppressive Disorders
- ☐ Stroke
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Hemophilia

Please list all prescription medication you are taking

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____
10 _____
11 _____
12 _____
ETC. _____

Please explain all 'Yes answers

_____

_____

Do you have any allergies or have you ever had an adverse reaction to any medication _____

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

Are you under the care of a physician? ☐ Yes ☐ No

For what conditions? _____

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

(Women) Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No Do you take birth control pills? ☐ 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 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 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*