

PATIENT REGISTRATION

Patient Information

SECTION 1

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

Address: \_\_\_\_\_ Suite/Unit/Apt #: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Mobile: \_\_\_\_\_ Pager: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Sec.#: \_\_\_\_\_ Drivers Lic.#: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Whom may we thank for referring you?: \_\_\_\_\_

SECTION 2

Sex:  Male  Female Marital Status:  Married  Single  Child

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Pharmacy Phone #: \_\_\_\_\_

Emergency Contact (Name & Number): \_\_\_\_\_

Responsible Party  
(if someone other than patient)

Same as Above

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

Address: \_\_\_\_\_ Suite/Unit/Apt #: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Mobile: \_\_\_\_\_ Pager: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Sec.#: \_\_\_\_\_ Drivers Lic.#: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Responsible Party is also Policy Holder for Patient  Primary Insurance Holder  Secondary Insurance Holder

Primary Insurance  
Information

Name of Insured: \_\_\_\_\_ Relation to Patient:  Self  Spouse  Child  Other

Insured Social Sec. No.: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Secondary Insurance  
Information

Name of Insured: \_\_\_\_\_ Relation to Patient:  Self  Spouse  Child  Other

Insured Social Sec. No.: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

MEDICAL HISTORY

Health Notice

Although dental personnel primarily treat the area in and around your mouth, this area of your body is an important part of your overall health and well-being. Health problems that you may have, or medication that you may be taking, could have an interrelationship with dentistry that may not be obvious. Please be mindful of this fact while completing the following questions. This information is kept strictly confidential. Thank you in advance.

General Health Questions

Are you under a physician's care now? Yes [ ] No [ ] Name: \_\_\_\_\_ Phone #: \_\_\_\_\_
Have you even been hospitalized or had a major operation? Yes [ ] No [ ] If yes, explain: \_\_\_\_\_
Have you ever had a serious head or neck injury? Yes [ ] No [ ] If yes, explain: \_\_\_\_\_
Are you taking any medications, pills, or drugs? Yes [ ] No [ ] If yes, explain: \_\_\_\_\_
Do you take, or have you taken Phen-Fen or Redux? Yes [ ] No [ ] If yes, when: \_\_\_\_\_
Are you on a special diet? Yes [ ] No [ ] If yes, explain: \_\_\_\_\_
Do you use tobacco? Yes [ ] No [ ]
Do you use controlled substances? Yes [ ] No [ ]
WOMEN are you... [ ] Pregnant? [ ] Trying to get pregnant? [ ] Nursing? [ ] Taking oral contraceptives?

Allergies

Are you allergic to any of the following?
[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Acrylic [ ] Metal [ ] Latex [ ] Local Anesthetics [ ] Sulfur Drugs
[ ] Other (explain): \_\_\_\_\_

Medical Conditions

Do you have, or have you had, any of the following?
[ ] AIDS / HIV Positive [ ] Chest Pains [ ] Frequent Headaches [ ] Irregular Heartbeat [ ] Scarlet Fever
[ ] Alzheimer's Disease [ ] Cold Sores / Fever Blisters [ ] Genital Herpes [ ] Kidney Problems [ ] Shingles
[ ] Anaphylaxis [ ] Congenital Heart Disorder [ ] Glaucoma [ ] Leukemia [ ] Sickle Cell Disease
[ ] Anemia [ ] Convulsions [ ] Hay Fever [ ] Liver Disease [ ] Sinus Trouble
[ ] Angina [ ] Cortisone Medicine [ ] Heart Attack / Failure [ ] Low Blood Pressure [ ] Spina Bifida
[ ] Arthritis / Gout [ ] Diabetes [ ] Heart Murmur [ ] Lung Disease [ ] Stomach / Intestinal Disease
[ ] Artificial Heart Valve [ ] Drug Addiction [ ] Heart Pace Maker [ ] Mitral Valve Prolapse [ ] Stroke
[ ] Artificial Joint [ ] Easily Winded [ ] Heart Trouble / Disease [ ] Pain in Jaw Joints [ ] Swelling of Limbs
[ ] Asthma [ ] Emphysema [ ] Hemophilia [ ] Parathyroid Disease [ ] Thyroid Disease
[ ] Blood Disease [ ] Epilepsy or Seizures [ ] Hepatitis A [ ] Psychiatric Care [ ] Tonsillitis
[ ] Blood Transfusion [ ] Excessive Bleeding [ ] Hepatitis B or C [ ] Radiation Treatments [ ] Tuberculosis
[ ] Breathing Problem [ ] Excessive Thirst [ ] Herpes [ ] Recent Weight Loss [ ] Tumors or Growths
[ ] Bruise Easily [ ] Fainting Spells / Dizziness [ ] High Blood Pressure [ ] Renal Dialysis [ ] Ulcers
[ ] Cancer [ ] Frequent Cough [ ] Hives or Rash [ ] Rheumatic Fever [ ] Veneral Disease
[ ] Chemotherapy [ ] Frequent Diarrhea [ ] Hypoglycemia [ ] Rheumatism [ ] Yellow Jaundice

Have you ever had any serious illness not listed above? \_\_\_\_\_
Please explain: \_\_\_\_\_

Comments

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_