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PATIENT REGISTRATION & HEALTH HISTORY

ANSWERS TO THE FOLLOWING QUESTIONS ARE FOR OUR RECORDS ONLY AND WILL BE CONSIDERED CONFIDENTIAL

NAME: FIRST MIDDLE LAST DATE:

PREFERS TO BE CALLED: DATE OF BIRTH: SSN#

MAILING ADDRESS: STREET CITY STATE ZIP

HOME PHONE#: CELL PHONE# E-MAIL:
WHEN CONFIRMING APPOINTMENTS WHICH OF THE FOLLOWING DO YOU PREFER: HOME WORK CELL E-MAIL

EMPLOYER: OCCUPATION:

BUSINESS PHONE#: BUSINESS ADDRESS:

MARITAL STATUS: () SINGLE () MARRIED () DIVORCED () WIDOWED

SPOUSE'S NAME: (If Applicable) EMPLOYER:

BUSINESS PHONE#: BUSINESS ADDRESS:

EMERGENCY CONTACT: PHONE: RELATIONSHIP TO PATIENT:

FAMILY DENTIST: WHOM MAY WE THANK FOR REFERRING YOU?

IS PATIENT A MINOR? IF SO, PLEASE COMPLETE THE FOLLOWING:
PARENT/GUARDIAN NAME: FIRST MIDDLE LAST
MAILING ADDRESS: (IF DIFFERENT FROM ABOVE) STREET CITY STATE ZIP
HOME PHONE#: CELL PHONE# BUSINESS PHONE:

DENTAL INSURANCE INFORMATION:
DO YOU HAVE DENTAL INSURANCE? IF SO, PLEASE COMPLETE THE FOLLOWING:
INSURANCE COMPANY NAME: PHONE#:

ADDRESS:

SUBSCRIBER NAME: SUBSCRIBER SSN#:

SUBSCRIBER DATE OF BIRTH: GROUP #: ID#:

MEDICAL INSURANCE INFORMATION:
DO YOU HAVE MEDICAL INSURANCE? IF SO, PLEASE COMPLETE THE FOLLOWING:

INSURANCE COMPANY NAME: PHONE#:

ADDRESS:

SUBSCRIBER NAME: SUBSCRIBER SSN#:

SUBSCRIBER DATE OF BIRTH: GROUP #: ID#:

HEALTH HISTORY

PHYSICIAN'S NAME: _____ ADDRESS: _____ PHONE: _____

HAVE YOU BEEN HOSPITALIZED OR HAD A SERIOUS ILLNESS WITHIN THE PAST FIVE YEARS? YES ___ NO ___

PLEASE CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST OR HAVE AT THE PRESENT TIME:

RHEUMATIC FEVER	TUBERCULOSIS	COMMUNICABLE SEXUAL DISEASES
HEART DEFECTS	LIVER DISEASE	HIV/AIDS
ARTHRITIS	TUMORS	CARDIOVASCULAR DISEASE
HEART BYPASS	STOMACH PROBLEMS	HIGH BLOOD PRESSURE
ANEMIA	ANGINA	ABNORMAL BLEEDING
THYROID	KIDNEY TROUBLE	HAY FEVER
ASTHMA	GLAUCOMA	ARTIFICIAL JOINTS
SEIZURES	DIABETES	HEPATITIS A, B, OR C
ORGAN TRANSPLANT	CANCER	MITRAVALVE PROLAPSE
BLOOD TRANSFUSION	EASY BRUISING	CONGENITAL HEART FAILURE
ULCERS	PACEMAKER	OTHER:

PLEASE CHECK IF YOU ARE TAKING ANY OF THE FOLLOWING:

ANTIBIOTICS OR SULFA DRUGS	ASPIRIN	DIABETES MEDICATION
BLOOD THINNERS	STEROIDS	HEART MEDICATION
TRANQUILIZERS	NITROGLYCERIN	HIGH BLOOD PRESSURE MEDICATION
ORAL CONTRACEPTIVES	HORMONES	OTHER (INCLUDING HERBAL):

PLEASE CHECK ANY OF THE FOLLOWING TO WHICH YOU ARE ALLERGIC:

LOCAL ANESTHETICS (NOVACAIN)	ASPIRIN	SULFA DRUGS
CODEINE OR OTHER NARCOTICS	SEDATIVES	PENICILLIN
LATEX ALLERGY	IODINE	TETRACYCLINE
OTHER ANTIBIOTICS - PLEASE LIST:		
OTHER:		

ARE YOU A SMOKER? YES ___ NO ___ IF SO, HOW OFTEN? _____

ARE YOU INTERESTED IN QUITTING? VERY ___ SOMEWHAT ___ NOT AT ALL ___

SHOULD WE BE MADE AWARE OF ANY DISEASE, CONDITION, PROBLEM OR FAMILY HISTORY? YES ___ NO ___
IF SO, PLEASE EXPLAIN: _____

WOMEN: ARE YOU PREGNANT? YES ___ NO ___
DO YOU HAVE PROBLEMS WITH YOUR MENSTRUAL CYCLE? YES ___ NO ___

REVIEW DATE	CLIENT'S SIGNATURE/INITIALS	STAFF MEMBER

RELEASE & CONSENT SECTION:

I HEREBY CONSENT TO AN EXAMINATION AND DEEM THAT ALL INFORMATION LISTED IS ACCURATE AND CURRENT. THE UNDERSIGNED HEREBY AUTHORIZES THE DOCTOR TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS OR ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE TO MAKE A THOROUGH DIAGNOSIS OF THE PATIENT'S DENTAL NEEDS. I WILL ALSO NOTIFY YOU OF ANY CHANGES IN MY HEALTH STATUS IN THE FUTURE.

PATIENT SIGNATURE: _____ DATE: _____

PARENT IF PATIENT IS A MINOR: _____ DATE: _____