PATIENT REGISTRATION AND MEDICAL HISTORY

(PLEASE PRINT)

PATIENT _____ Home Phone _____
First Name Last Name

Cell Phone _____

Street Address _____ City _____ State _____ Zip _____

Sex: M F Age _____ Date of Birth _____ [Circle One] Single Married Widowed Separated Divorced

Employed by _____ Occupation _____ SS # _____

Business Address _____ City _____ Zip _____ Phone _____

SPOUSE NAME _____ Occupation _____ SS # _____

Employed by _____ Business Phone _____

Business Address _____ City _____ Zip _____

DENTAL INSURANCE _____ Group Number _____

PERSON INSURANCE IS UNDER _____ Relationship to Patient _____

INSURED'S SOCIAL SECURITY # _____ Date of Birth _____

Employer _____ Address _____ City _____ Zip _____

In case of an emergency, who should be notified? _____ Phone _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____ **Pharmacy #** _____

(Check those that apply to patient)

__AIDS	__**Codeine Allergy**	__Heart Disease	__Nervous Disorder	__Stomach Problems
__Anemia	__Cortisone Treatment	__Heart Murmur	__Pacemaker	__Stroke
__Arthritis	__**Coumadin**	__Hemophilia	__**Penicillin Allergy**	__**Sulfur Allergy**
__**Artificial Joints/Valves**	__Diabetes	__Hepatitis	__Pregnant	__Swollen Neck Glands
__**Asprin Allergy**	__Epilepsy	__High Blood Pressure	__Psychiatric Care	__Thyroid Disease
__Asthma	__Excessive Bleeding	__HIV Positive	__Radiation Treatment	__Tuberculosis
__Bi-Pass Surgery	__Fainting/Dizziness	__Kidney Disease	__Recent Weight Loss	__Tumors
__Blood Disease	__Glaucoma	__Liver Disease	__Respiratory Disease	__Ulcers
__Cancer/Chemo	__Growths	__Low Blood Pressure	__Rheumatic Fever	__Venerial Disease
__Chemical Dependency	__Head Injuries	__Mental Disorders	__Sinus Problems	__Other _____
__Circulatory Problems	__Headaches	__Mitral Valve Prolapse	__Special Diet	_____

List *DRUG ALLERGIES* or medications you've had bad reactions to _____

Have you ever responded adversely to medical or dental treatment? _____

Are you under the care of a physician? Yes No For what condition? _____

List *MEDICATIONS* you're currently taking _____

_____

If patient is a child, what is weight? _____ (Women) Do you suspect you are pregnant? Yes No Are you nursing? Yes No

Is there anything else we should know about your medical history? _____

The above information is accurate and complete to the best of my knowledge and is only for the use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

_____

Date Signature