

PATIENT REGISTRATION

ID: _____ Chart ID: _____
 First Name: _____ Last Name: _____ Middle Initial: _____
 Patient Is: Policy Holder Preferred Name: _____
 Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____
 Address: _____ Address 2: _____
 City, State, Zip: _____ Pager: _____
 Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____
 Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

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

Patient Information

Address: _____ Address 2: _____
 City: _____ State / Zip: _____ Pager: _____
 Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____
 Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
 Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ I would like to receive correspondences via e-mail.

Section 2

Section 3

Employment Status: Full Time Part Time Retired Referred By: _____
 Student Status: Full Time Part Time Previous Dentist: _____
 Medicaid ID: _____ Pref. Dentist: _____ Emergency Contact: _____
 Employer ID: _____ Pref. Pharmacy: _____ Emergency Contact #: _____
 Carrier ID: _____ Pref. Hyg.: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
 Insured Soc. Sec: _____ Insured Birth Date: _____
 Employer: _____ Ins. Company: _____
 Address: _____ Address: _____
 Address 2: _____ Address 2: _____
 City,State,Zip: _____ City,State,Zip: _____
 Rem. Benefits: .00 Rem. Deduct: .00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
 Insured Soc. Sec: _____ Insured Birth Date: _____
 Employer: _____ Ins. Company: _____
 Address: _____ Address: _____
 Address 2: _____ Address 2: _____
 City,State,Zip: _____ City,State,Zip: _____
 Rem. Benefits: .00 Rem. Deduct: .00

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you 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 _____
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____
- Are you on a special diet? Yes No _____
- Do you use tobacco? Yes No _____
- Do you use controlled substances? Yes No _____

Women: Are you

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs
 Other If yes, please explain: _____

Do you have, or have you had, any of the following?

| | | | | | | | | | | | |
|---------------------------|-----|----|---------------------------|-----|----|-----------------------|-----|----|----------------------------|-----|----|
| AIDS/HIV Positive | Yes | No | Cortisone Medicine | Yes | No | Hemophilia | Yes | No | Radiation Treatments | Yes | No |
| Alzheimer's Disease | Yes | No | Diabetes | Yes | No | Hepatitis A | Yes | No | Recent Weight Loss | Yes | No |
| Anaphylaxis | Yes | No | Drug Addiction | Yes | No | Hepatitis B or C | Yes | No | Renal Dialysis | Yes | No |
| Anemia | Yes | No | Easily Winded | Yes | No | Herpes | Yes | No | Rheumatic Fever | Yes | No |
| Angina | Yes | No | Emphysema | Yes | No | High Blood Pressure | Yes | No | Rheumatism | Yes | No |
| Arthritis/Gout | Yes | No | Epilepsy or Seizures | Yes | No | High Cholesterol | Yes | No | Scarlet Fever | Yes | No |
| Artificial Heart Valve | Yes | No | Excessive Bleeding | Yes | No | Hives or Rash | Yes | No | Shingles | Yes | No |
| Artificial Joint | Yes | No | Excessive Thirst | Yes | No | Hypoglycemia | Yes | No | Sickle Cell Disease | Yes | No |
| Asthma | Yes | No | Fainting Spells/Dizziness | Yes | No | Irregular Heartbeat | Yes | No | Sinus Trouble | Yes | No |
| Blood Disease | Yes | No | Frequent Cough | Yes | No | Kidney Problems | Yes | No | Spina Bifida | Yes | No |
| Blood Transfusion | Yes | No | Frequent Diarrhea | Yes | No | Leukemia | Yes | No | Stomach/Intestinal Disease | Yes | No |
| Breathing Problem | Yes | No | Frequent Headaches | Yes | No | Liver Disease | Yes | No | Stroke | Yes | No |
| Bruise Easily | Yes | No | Genital Herpes | Yes | No | Low Blood Pressure | Yes | No | Swelling of Limbs | Yes | No |
| Cancer | Yes | No | Glaucoma | Yes | No | Lung Disease | Yes | No | Thyroid Disease | Yes | No |
| Chemotherapy | Yes | No | Hay Fever | Yes | No | Mitral Valve Prolapse | Yes | No | Tonsillitis | Yes | No |
| Chest Pains | Yes | No | Heart Attack/Failure | Yes | No | Osteoporosis | Yes | No | Tuberculosis | Yes | No |
| Cold Sores/Fever Blisters | Yes | No | Heart Murmur | Yes | No | Pain in Jaw Joints | Yes | No | Tumors or Growths | Yes | No |
| Congenital Heart Disorder | Yes | No | Heart Pacemaker | Yes | No | Parathyroid Disease | Yes | No | Ulcers | Yes | No |
| Convulsions | Yes | No | Heart Trouble/Disease | Yes | No | Psychiatric Care | Yes | No | Venereal Disease | Yes | No |
| | | | | | | | | | Yellow Jaundice | Yes | No |

Have you ever had any serious illness not listed above? Yes No

Comments: _____

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 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 _____