PATIENT REGISTRATION AND MEDICAL HISTORY

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

LAST NAME		FIRST NAME	MIDDLE INIT.
ADDRESS			APT#
CITY	STATE	ZIP	
HOME PHONE		CELL PHONE	
BIRTHDATE	AGE	MALE / FEMALE	MARITAL STATUS
RESPONSIBLE PARTY		SOCIAL SECURITY#	

DO YOU HAVE DENTAL INSURANCE? (Please circle): NO YES (Please hand ID and insurance card to receptionist)

1. Whom may we thank for your referral? ______________________________
2. What is the reason for your visit today? ______________________________
3. Have you had problems or unusual reactions to prior dental treatment? ______________________
4. Are you currently seeing a physician for any medical related problems? NO YES ________________
5. Do you have any medically related injuries or have had any major surgeries? NO YES Please explain:
____
6. Please list any medications you are taking (including over the counter drugs such as Aspirin, Ibuprofen, Tylenol)
____
7. Please list any known allergies (medications and/or food products)
____
8. Please circle "Yes" or "No" by each item:

Congestive heart failure	NO YES	Kidney Trouble	NO YES	Venereal Disease	NO YES
Heart Disease or Attack	NO YES	Ulcers	NO YES	HIV Positive/AIDS	NO YES
Angina/Chest Pain	NO YES	Diabetes	NO YES	Cold sores/fever blisters	NO YES
Congenital Heart Disease	NO YES	Thyroid Problems	NO YES	Blood Transfusion	NO YES
Heart Murmur	NO YES	Glaucoma	NO YES	Hemophilia	NO YES
High Blood Pressure	NO YES	Cosmetic Surgery	NO YES	Abnormal Bleeding	NO YES
Mitral Valve Prolapse	NO YES	Emphysema	NO YES	Anemia	NO YES
Artificial Heart Valve	NO YES	Tuberculosis	NO YES	Sickle Cell Disease	NO YES
Heart Pacemaker	NO YES	Asthma	NO YES	Epilepsy or Seizures	NO YES
Heart Surgery	NO YES	Respiratory Problems	NO YES	Fainting or Dizzy Spells	NO YES
Blood Thinners	NO YES	Allergies/Hives	NO YES	Psychiatric Treatment	NO YES
Stroke	NO YES	Cancer/Tumor	NO YES	Liver Disease	NO YES
Rheumatic Fever	NO YES	Radiation therapy	NO YES	Hepatitis A	NO YES
Arthritis	NO YES	Artificial joints	NO YES	Hepatitis B	NO YES
Cortisone Medicine	NO YES	Tobacco Use	NO YES	Compromised Immune System	NO YES

OTHER (Please explain): ____
____

FOR WOMEN ONLY: Are you pregnant? NO YES What month?_____ Are you nursing?____ Are you taking birth control pills?___

I UNDERSTAND THE ABOVE INFORMATION IS NECESSARY TO PROVIDE ME WITH DENTAL CARE IN A SAFE AND EFFICIENT MANNER. I HAVE ANSWERED ALL QUESTIONS TRUTHFULLY AND TO THE BEST OF MY KNOWLEDGE. I ACKNOWLEDGE THAT PAYMENT IS DUE AT TIME OF TREATMENT, UNLESS OTHER ARRANGEMENTS ARE MADE AND ACCEPT FULL RESPONSIBILITY FOR ALL CHARGES NOT COVERED BY INSURANCE.

Signature of Patient or Guardian (Responsible Party) ______________________________ **Date**____________

Medical History Update:

1. Doctor initial ________ Date: _______________ Notes: ______________________________
2. Doctor initial ________ Date: _______________ Notes: ______________________________
3. Doctor initial ________ Date: _______________ Notes: ______________________________