

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	MARITAL STATUS:	
BIRTHDATE	AGE	MALE / FEMALE	E-MAIL:	
RESPONSIBLE PARTY		MAY WE CONTACT YOU BY TEXT MESSAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO		

1. Whom may we thank for your referral? _____
2. What is the reason for your visit today? _____
3. When was your last visit to the dentist? _____
4. Do you have any medically related injuries or have had any major surgeries? NO YES Please explain

5. Please list any medications you are taking (including over the counter drugs such as Aspirin, Ibuprofen, Tylenol)

6. Please list any known allergies to medications.

7. Have you previously taken any biphosphonate medications (ex Boniva, Fosamax, Actonel, etc) usually prescribed for osteoporosis? Y or N If yes, then when did you stop taking them? _____
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	Chemotherapy	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** _____