Patient Registration

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Responsible Party (If someone OTHER than patient, please fill out below):

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Mailing (if different): _____

City, State, Zip Code:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Birth Date: _____ Age: _____ Social Security#: _____ Drivers License: _____

Patient Information:

Address: _____ Mailing (if different): _____

City, State, Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Birth Date: _____ Age: _____ Social Security#: _____ Drivers License: _____

Email: _____ *Would you like to receive correspondences via e-mail?* Y or N

Sex: ○ Male or ○ Female Marital Status: ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed

Employment Status: ○ Full Time ○ Part Time ○ Retired ○ Unemployed **Emergency Contact:** _____

Student Status: ○ Full Time ○Part Time ○ Neither **Phone#:** _____

Primary Insurance Information:

Name of insured: _____ Relationship to Pt: _____ Social Security#: _____ Birth Date:_____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Secondary Insurance Information:

Name of insured: _____ Relationship to Pt: _____ Social Security#: _____ Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Medical History

Are you under a physicians Care? .....Y N
Who is your Primary Care Doctor? _____
Have you ever been hospitalized or had a major operation?...Y N
Are you taking any medications, pills, or drugs?.....Y N
Do you take, or have you taken Phen-fen or Redux?..... Y N

Are you on a special Diet?..Y N
Do you use tobacco?..... Y N
Have you ever taken Fosamax, Boniva, Actonel, or any other medications that contain biphosphonates?... Y N

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

_____
_____
_____
_____

Are you allergic to any of the following? (Please CIRCLE if yes)

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal

Latex Sulfa Drugs OTHER: _____

***Women**:*

Are you pregnant/ trying to get pregnant? Y N *Taking Oral Contraceptives? Y N* *Nursing? Y N*

Do you have, or have you had, any of the following? (√ those that apply)

____ AIDS/HIV	____ Cortisone Medicine	____Hemophilia	____Radiation Treatments
____ Alzheimer's Disease	____Diabetes	____Hepatitis A	____Recent Weight Loss
____Anaphylaxis	____Drug Addiction	____Hepatitis B or C	____Renal Disease
____Anemia	____Easily Winded	____Herpes	____Rheumatic Fever
____Angina	____Emphysema	____High Blood Pressure	____Rheumatism
____Arthritis/Gout	____Epilepsy/seizures	____High Cholesterol	____Scarlet Fever
____Artificial Heart Valve	____Excessive Bleeding	____Hives/Rash	____Shingles
____Artificial Joint	____Excessive Thirst	____Hypoglycemia	____Sickle Cell Disease
____Asthma	____Fainting/Dizziness	____Irregular Heartbeat	____ Sinus Trouble
____Blood Disease	____Frequent Cough	____Kidney Problems	____Spina Bifida
____Blood Transfusion	____Frequent Diarrhea	____Leukemia	____Stomach Disease
____Breathing Problem	____Frequent Headaches	____Liver Disease	____Stroke
____Bruise Easily	____Genital Herpes	____Low Blood Pressure	____Swelling of Limbs
____Cancer	____Glaucoma	____Lung Disease	____Thyroid Disease
____Chemotherapy	____Hay Fever	____Mitral Valve Prolapse	____Tonsilitis
____Chest Pains	____Heart Attack/Failure	____Osteoporosis	____Tumors/Growths
____Cold Sores	____Heart Murmur	____Pain in Jaw Joints	____Ulcers
____Convulsions	____Heart Trouble/Disease	____Parathyroid Disease	____Venereal Disease

Do you have any other serious illness NOT listed above? Y N _____

Comments/Questions? Is there anything NOT listed on this form you feel we need to know?

_____
_____

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 _____