# PATIENT REGISTRATION AND MEDICAL HISTORY

Date_____ (Please Print) Home Phone_____ Cell_____

Patient _____
Last Name First Name Initial Preferred Name

Street Address_____City _____State_____Zip_____

Sex: ☐ M ☐ F Age____Birthdate_____ ☐Single ☐ Married ☐Widowed ☐ Separated ☐ Divorced

Insured Employer _____Occupation_____

Business Address_____ _Business Phone_____

Who is responsible for this account?_____Relationship to Patient_____

Insured's Social Security / ID #_____Insured's Date of Birth_____Spouse's Social Security _____

Name of Dental Insurance Company_____Group Number_____

In case of emergency, who should be notified?_____Phone_____

Whom may we thank for referring you?_____

## MEDICAL HISTORY

Physician's Name_____Date of Last Physical_____

Have you ever had any of the following? (check boxes that apply)

| | | | |
|---|---|---|---|
| ☐ Heart Murmur | ☐ Back Problems | ☐ Chronic Diarrhea | ☐ Sinus Problems |
| ☐ Heart Problems | ☐ Diabetes | ☐ Allergies to Anesthetics | ☐ "A.I.D.S." or Other |
| ☐ High Blood Pressure | ☐ Respiratory Disease | ☐ Allergies to Medicine or Drugs | ☐ Immunosuppressive Disorders |
| ☐ Low Blood Pressure | ☐ Epilepsy | ☐ General Allergies | ☐ Stroke |
| ☐ Circulatory Problems | ☐ Headaches | ☐ Blood Disease | ☐ Ulcer |
| ☐ Nervous Problems | ☐ Hepatitis, Jaundice or | ☐ Arthritis | ☐ Venereal Disease |
| ☐ Radiation Treatment | ☐ Liver Disease | ☐ Special Diet | ☐ Chemical Dependency |
| ☐ Artificial Heart Valves or Joints | ☐ Cancer | ☐ Swollen Neck Glands | ☐ Hemophilia |
| ☐ Recent Weight Loss | ☐ Psychiatric Care | ☐ Rheumatic Fever | ☐ Latex Allergy |

## DENTAL HISTORY

*Have you had any adverse reaction to Dental materials? Yes___ No___

☐ Have you ever been told you need to pre-medicate?_____
☐ Bleeding Gums as a result of brushing or toothpick use
☐ Gums red, swollen or tender
☐ Gums pulling away from teeth
☐ Pus between teeth & gums when gums are pressed
☐ Permanent teeth are loose or separating
☐ Change in the way teeth fit together
☐ Change in the fit of partial dentures
☐ Bad breath

Do you smoke?_____

Have you ever responded adversely to medical or dental treatment?_____If so, please specify_____

Are you taking any medication at this time?___If so, please list medications_____

Are you under the care of a physician? ☐Yes ☐ No Please list conditions_____

Do you have any allergies?_____
If the patient is a child, what is his/her weight?_____

(Women) Do you suspect that 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 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/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____Signature_____