

PATIENT REGISTRATION

Patient Name _____
FIRST MIDDLE LAST

Parent's / Guardian's / Spouse's Name _____

Patient Address _____
STREET

_____ CITY STATE ZIP CODE

Home Phone # _____ Work Ph. # _____ Cell Ph. # _____

Age _____ Birth Date ____/____/____ Sex _____ Marital Status _____

Social Security # _____ Driver's License # _____

Employer _____ Occupation _____

E-mail Address _____

How did you hear about us? _____

INSURANCE INFORMATION

(If patient is covered by dental insurance, please fill out this section)

Insured Party _____
NAME BIRTHDATE SOCIAL SECURITY #

Relation to Patient _____ Name of Insurance Company _____

Employer _____
COMPANY NAME PHONE #

OPTIONAL PERMISSION

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PATIENT'S OR PARENT'S/GUARDIAN'S SIGNATURE DATE

PATIENT HEALTH HISTORY

Emergency Contact _____
NAME RELATIONSHIP TO PATIENT PHONE NUMBER

Physician _____
NAME PHONE NUMBER

1. Have you been treated in the hospital during the past 2 years? If so, please explain. **YES NO**

2. Have you been under the care of a physician during the past 2 years? If so, please explain. **YES NO**

3. Have you taken any kind of medicine or drugs during the past 2 years? If so, please list. (include sleeping pills, oral contraceptives, tranquilizers, alcohol, etc.) **YES NO**

4. Are you allergic to penicillin, codeine, sulfa drugs or any other medications? If so, please list. **YES NO**

5. Have you been diagnosed with AIDS or are you HIV positive? **YES NO**

6. Have you ever had a Blood Transfusion? If yes, enter date: **YES NO**

7. **Circle any of the following conditions that you currently have or have been treated for:**

- | | | | |
|---------------------------|-----------------|----------------------|----------------------------|
| *Heart Murmur | Ulcers | Arthritis | High Blood Pressure |
| *Congenital Heart Lesions | Cough | Stroke | Gastrointestinal disorders |
| *Mitral Valve Prolapse | Diabetes | Epilepsy | Seizure Disorders |
| *Any type of Implant | Tuberculosis | Bronchitis | Down's Syndrome |
| *Rheumatic Fever | Emphysema | Jaundice | Hepatitis: Type _____ |
| *Steroid Treatment | Glaucoma | Anemia | Venereal Disease |
| *Heart Valve Replacement | Kidney Disorder | Heart Disease | Sinus Trouble |
| *Hip / Joint Replacement | Asthma | Other: _____ | |

8. (WOMEN) Are you pregnant or nursing now? If so, how many months? **YES NO**

9. Are you wearing any type of removable dental appliance? **YES NO**

10. Do you use any tobacco products? If so, what type and how much? **YES NO**

11. List all medications you are currently taking, and why you are taking them: _____

12. Do you get headaches? **YES NO** Frequency? _____ Severity? _____

13. Is there anything you want to talk to the doctor about today? _____

Patient's or Parent's/Guardian's Signature

Date