PATIENT REGISTRATION AND HEALTH HISTORY

PATIENT INFORMATION

Patient's Name: _____ Date:_____
LAST FIRST MI

Address:_____
STREET CITY STATE ZIP

Home Phone:_____ Cell Phone _____ Work Phone:_____

E-Mail:_____ Birth Date:_____ Social Security # _____

What is the best way to contact you? HOME ☐ CELL ☐ WORK ☐ E-MAIL ☐

Whom may we thank for referring you to our office?_____

RESPONSIBLE PARTY INFORMATION (If different than the patient)

Name:_____ Relationship to Patient:_____

Mailing Address:_____

How long at this address?:_____ Home Phone:_____ Work Phone:_____

Birth Date:_____Social Security #_____

Employer:_____ Occupation:_____ Years Employed:_____

Spouse's Name:_____ Relationship to Patient:_____

Employer:_____ Occupation: _____ Years Employed:_____

Birth Date:_____Social Security #_____

INSURANCE INFORMATION

Policy Holder: _____ ID # or SSN # of Policy Holder: _____

Insurance Company: _____ Group # _____ Local #: _____

Insurance Company Address:_____

Do you have dual coverage? YES☐ NO☐ If Yes:_____

Policy Holder: _____ ID # or SSN # of Policy Holder: _____

Insurance Company: _____ Group # _____ Local #: _____

Insurance Company Address:_____

EMERGENCY INFORMATION

Name of nearest relative: _____

Complete Address:_____

Phone Number:_____

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		PLEASE CHECK YES	NO
1.	Are you having pain or discomfort at this time?	☐	☐
2.	Do you feel nervous about having dental treatment?	☐	☐
3.	Have you ever had a bad experience in the dental office?	☐	☐
4.	Have you been in patient in the hospital during the past two years?	☐	☐
5.	Have you been under the care of a medical doctor during the past two years?	☐	☐

Physician's Name:_____ Address: _____ Phone Number:_____

6. Have you taken any medicine or drugs during the past two weeks? **YES** **NO**

   Are you now taking any medication, drugs, or pills? **YES** **NO**

   If yes, please list:_____

7. Are you allergic or have you reacted adversely to any of the following medications?

Aspirin	Erythromycin	Penicillin
Darvon	Tetracycline	Local Anesthetic
Codeine	Percodan	(Novocain or Xylocaine)
Demerol	Valium	Sleeping Pills
Nitrous Oxide	Scopolamine	Other Antibiotics (Nembutal)

8. Are you aware of being allergic to any other medications or substances? **YES** **NO**

9. Circle any of the following which you have had or have at present:

Heart Failure	Emphysema	Hepatitis A (infection)
Heart Disease or Attack	Cough	Hepatitis B (serum)
Angina Pectoris	Tuberculosis (TB)	Liver Disease
High Blood Pressure	Asthma	Yellow Jaundice
Heart Murmur	Hay Fever	Blood Transfusion
Rheumatic Fever	Sinus Trouble	Drug Addiction
Congenital Heart Lesions	Allergies or Hives	Hemophilia
Scarlet Fever	Diabetes	Venereal Disease (Syphillis,
Artificial Heart Valve	Thyroid Disease	Gonorrhea)
Heart Pacemaker	X-ray or Cobalt Treatment	Cold Sores
Heart Surgery	Chemotherapy (Cancer, Leukemia)	Fever Blisters
Artificial Joints (Hip, Kidney	Arthritis	Epilepsy or Siezures
Anemia	Rheumatism	Fainting or Dizzy Spells
Stroke	Cortisone Medicine	Nervousness
Kidney Trouble	Glaucoma	Psychiatric Treatment
Ulcers	Pain in Jaw Joints	Sickle Cell Disease
Cosmetic Surgery	Bruise Easily	HIV/AIDS

10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath or because you are very tired?
11. Do your ankles swell during the day? **YES** **NO**
12. Do you use more than 2 pillows to sleep? **YES** **NO**
13. Have you lost or gained more than 10lbs in the past year? **YES** **NO**
14. Do you ever wake up from sleep short of breath? **YES** **NO**
15. Are you on a special diet? **YES** **NO**
16. Has your medical doctor ever said you have cancer or a tumor? **YES** **NO**
17. Do you have any disease, condition, or problem not listed? **YES** **NO**

FOR WOMEN ONLY:

Are you pregnant: YES ☐ NO ☐ If yes, what month?_____ Are you nursing: YES ☐ NO ☐ Are you taking birth control pills? YES ☐ NO ☐

THE ABOVE INFORMATION IS TRUE

Patient Signature:_____ Date: _____

CONSENT:

The undersigned herby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient)_____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand that the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental service provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made.

Patient Signature:_____ Date: _____

Patient or Responsible Party _____ Relationship to Patient: _____