PATIENT REGISTRATION

Date _____

NAME MR / MRS / MS / DR			SEX M-F	BIRTHDATE	AGE
ADDRESS	APT.	ZIP CODE	HOME PHONE		
CELL PHONE	SS#	MARITAL STATUS	SPOUSE		
BUSINESS ADDRESS	BUSINESS PHONE	OCCUPATION			
REFERRED TO US BY	PERSON RESPONSIBLE FOR ACCOUNT				

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insured Employer _____

Insured's SS# _____ Group # ____ Local # ____

Medical Insurance _____ policy # _____

Insured's date of birth:

If you have double dental insurance coverage complete this for the second coverage.

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insured Employer _____

Insured's SS# _____ Group # ____ Local # ____

MEDICAL HISTORY

Name of physician_____

Have you been under your physician's care during the past two years? . . . . . Yes No

Have you been a patient in the hospital during the past five years? . Yes No

Are you currently taking any medications or drugs now?. Yes No

If yes, please list _____

Are you aware of having an allergic reaction to any of the following:

Local anesthetics (Novocaine) . . . . . Yes No

Antibiotics (Penicillin, Tetracycline etc.) . . . . . Yes No

Pain medications (aspirin, etc.) . . . . . Yes No

Codeine . . . . . Yes No

Other _____

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart Disease (Surgery; Attack, Stroke) . . . . . Yes No

Chest Pain (Angina) . . . . . Yes No

Heart Murmur (Mitral Valve) . . . . . Yes No

High Blood Pressure . . . . . Yes No

Heart Pacemaker . . . . . Yes No

Rheumatic Fever . . . . . Yes No

Swollen Ankles . . . . . Yes No

Fainting . . . . . Yes No

Dizzy Spells . . . . . Yes No

Emphysema . . . . . Yes No

Chronic Cough . . . . . Yes No

Tuberculosis . . . . . Yes No

Asthma/Hay Fever . . . . . Yes No

Sinus Trouble . . . . . Yes No

Hepatitis . . . . . Yes No

Liver Disease . . . . . Yes No

Bruise Easily . . . . . Yes No

Bleeding Problem . . . . . Yes No

Addiction (Drug, Alcohol) . . . . . Yes No

Blood Transfusion . . . . . Yes No

Blood Disorder . . . . . Yes No

Anemia . . . . . Yes No

Diabetes . . . . . Yes No

Arthritis/Rheumatism . . . . . Yes No

Artificial Joints (Hip, knee) . . . . . Yes No

Ulcers . . . . . Yes No

Kidney Trouble . . . . . Yes No

Latex Sensitivity . . . . . Yes No

Thyroid Problems . . . . . Yes No

Glaucoma . . . . . Yes No

AIDS . . . . . Yes No

H.I.V. Positive . . . . . Yes No

Venereal Disease (Syphilis, Gonorrhea) . . . . . Yes No

Tumors (Cancer) . . . . . Yes No

Radiation Treatment . . . . . Yes No

Chemotherapy . . . . . Yes No

Epilepsy/Seizures, Neurologic . . . . . Yes No

Do you have or have had any disease, condition, or problem not listed above? . . . . . Yes No

If yes, please explain_____

Have you lost or gained more than 10 pounds in the past year?..... Yes No

Are you considered a nervous person? . . . . . Yes No

Have you ever had any personal counseling (psychiatric or psychological treatment)? . . . . . Yes No

Do you smoke/chew tobacco?

How much?_____

For how long?_____

Do you drink alcohol?_____

How much?_____

Women. Are you: Pregnant? Yes,_____ Months No

Taking birth control? . . . . . Yes No

Have you reached menopause? . . . . . Yes No

PATIENT Signature (Parent or Guardian of Child) _____ Date: _____

MEDICAL HISTORY REVIEW