PATIENT REGISTRATION

Name: _____
Last, First, Middle Initial, Preferred Name

☐ male
Date of Birth: _____ ☐ female Social Security Number: _____

Home Address: _____ Phone: _____

Employer: _____ Work Phone: _____

Spouse's Name: _____ Work Phone: _____

If Minor, Parent/Legal Guardian: _____

Nearest relative not living with you: _____ Phone: _____

Whom should we contact in case of emergency? _____ Phone: _____

Physician: _____ Phone: _____

Previous Dentist: _____ Phone: _____

Landlord: _____ Phone: _____

Who is financially responsible for these services? _____

Payment will be made today by: Cash _____ Check _____ Credit Card _____ Insurance _____

Insurance Company: _____

Whom may we thank for referring you to us? _____

Reason for today's visit: _____

As a courtesy to our patients, we confirm appointments. How may we reach you?

_____ Home _____ Work _____ Cell _____ With Another Family Member

Name: _____ Phone: _____

MEDICAL HISTORY

Have you ever had any of the following:

_____ Cancer
_____ Heart Murmur
_____ Rheumatic Fever
_____ Mitral Valve Prolapse
_____ Artificial Joints or Heart Valves
_____ High or Low Blood Pressure _____
_____ Other Heart Problems _____
_____ Recent Weight Loss or Gain
_____ Hepatitis, Jaundice, or Other Liver Problems
_____ Epilepsy
_____ Diabetes
_____ Mental Health Concerns _____
_____ Codeine Allergy
_____ Latex Allergy
_____ Penicillin Allergy
_____ Thyroid Disorder
_____ Anemia
_____ Blood Disease / Disorder
_____ Asthma
_____ Tuberculosis
_____ Other Lung Disease _____
_____ Allergies
_____ Sinus Problems
_____ Venereal Disease
_____ HIV / AIDS
_____ Drug / Alcohol Dependence
_____ Unusual Bleeding

Do you have any allergies or have you ever had a reaction to any drug or medication? _____

If so, what? _____

Have you been hospitalized or under a physician's care within the past two years? _____

If so, for what? _____

Are you taking any prescription medications or recreational drugs at this time (including aspirin and birth control)? _____

If so, what? _____

Have you ever responded adversely to any medical or dental treatment? _____

Do you use tobacco? _____ If so, what and how much? _____

(Women) Are you or do you suspect you are pregnant? _____ Are you nursing? _____

Have you ever been told by a physician that you must premedicate with a prescription antibiotic before dental treatment? _____

Is there anything else we should know about your medical history? _____

_____

_____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any and all professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify that this information is correct to the best of my knowledge. I will notify you of any changes in my health status or other information above. ALSO, SHOULD IT BECOME NECESSARY TO PLACE MY ACCOUNT WITH A COLLECTION AGENCY OR ATTORNEY, I AGREE TO PAY 35% COLLECTION COSTS AND ATTORNEY'S FEES IN ADDITION TO ALL OTHER SUMS DUE.