PATIENT REGISTRATION AND MEDICAL HISTORY

PATIENT INFORMATION

Name: _____ (Last) _____ (First) _____ (Preferred Name)

Address: _____ City: _____ State: _____ ZIP: _____

Sex: ☐ M ☐ F Age: _____ Birthdate: ___/___/___ Business Phone: (___) _____ Home Phone: (___) _____

Employer: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ ZIP: _____

☐ Spouse or ☐ Guardian Name: _____

Employer: _____ Occupation: _____ Business Phone: (___) _____

Business Address: _____ City: _____ State: _____ ZIP: _____

If patient is a student, name of school/college: _____ City: _____

Person to contact in case of emergency: _____ Phone: (___) _____

Whom may we thank for referring you? _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Responsible Party: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ ZIP: _____

DENTAL INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient: _____ Birthdate: ___/___/___

Insurance Company: _____ Group #: _____ Social Security #: _____

Ins. Co. Address: _____ City: _____ State: _____ ZIP: _____

Ins. Co. Phone: (___) _____ Deductible: $ _____ Max. Annual Benefit: $ _____ Effective: Date of Ins.: _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

Name of Insured: _____ Relationship to Patient: _____ Birthdate: ___/___/___

Insurance Company: _____ Group #: _____ Social Security #: _____

Ins. Co. Address: _____ City: _____ State: _____ ZIP: _____

Ins. Co. Phone: (___) _____ Deductible: $ _____ Max. Annual Benefit: $ _____ Effective: Date of Ins.: _____

MEDICAL HISTORY

Physician's Name: _____ Date of Last Physical: _____

Have you ever had, or do you currently have, any of the following (check "yes" or "no")?

Yes	*No*		*Yes*	*No*		*Yes*	*No*		*Yes*	*No*	
☐	☐	Heart Problems	☐	☐	Diabetes	☐	☐	Blood Disease	☐	☐	Sinus Problems
☐	☐	High Blood Pressure	☐	☐	Respiratory Disease, Asthma	☐	☐	Arthritis	☐	☐	Stroke
☐	☐	Low Blood Pressure	☐	☐	Epilepsy	☐	☐	Swollen Neck Glands	☐	☐	Ulcer
☐	☐	Circulatory Problems	☐	☐	Headaches	☐	☐	Rheumatic Fever	☐	☐	Venereal Disease
☐	☐	Nervous Problems	☐	☐	Cancer	☐	☐	Allergies to Anesthetics	☐	☐	Chemical Dependency
☐	☐	Radiation Treatment	☐	☐	Psychiatric Care	☐	☐	General Allergies	☐	☐	Hemophilia
☐	☐	Artificial Heart Valves or Joints	☐	☐	Hepatitis, Jaundice or Liver Disease	☐	☐	Allergies to Medicines or Drugs	☐	☐	AIDS or Other Immuno-suppressive Disorders

List any drug allergies or adverse reactions you have had to medications: _____

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

Are you taking any medication at this time? _____ If so, what? _____

Are you under the care of a physician? ☐ Yes ☐ No If so, for what conditions? _____

If patient is a child, what is his/her weight? _____

Women: Are you or might you be pregnant? ☐ Yes ☐ No If yes, how many months? _____ 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. I understand that I am responsible for all costs of dental treatment.

Signature: _____ Date: _____