

# PATIENT REGISTRATION AND MEDICAL HISTORY

Date \_\_\_\_\_ (PLEASE PRINT) Home Phone (\_\_\_\_) \_\_\_\_\_

Patient \_\_\_\_\_  
Last Name First Name Middle Initial Preferred Name

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years

Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_ Employer/School Phone (\_\_\_\_) \_\_\_\_\_

Spouse/Parent Name \_\_\_\_\_ Spouse/Parent Birthdate \_\_\_\_\_

Spouse/Parent Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Social Security # \_\_\_\_\_ Spouse/Parent's Social Security # \_\_\_\_\_

Name of Dental Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_

In case of emergency, who should be notified? \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of Last Physical \_\_\_\_\_

Have you ever had any of the following? (check boxes that apply):

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Allergies                                      | <input type="checkbox"/> Epilepsy                             | <input type="checkbox"/> Pacemaker           |
| <input type="checkbox"/> Arthritis                                      | <input type="checkbox"/> Headaches                            | <input type="checkbox"/> Psychiatric Care    |
| <input type="checkbox"/> Artificial Heart Valves or Joints, Screws, etc | <input type="checkbox"/> Heart Murmur                         | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Back Problems                                  | <input type="checkbox"/> Heart Problems                       | <input type="checkbox"/> Recent Weight Loss  |
| <input type="checkbox"/> Bleeding Abnormally                            | <input type="checkbox"/> Hemophilia                           | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Blood Disease                                  | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease | <input type="checkbox"/> Rheumatic Fever     |
| <input type="checkbox"/> Cancer   | <input type="checkbox"/> Hernia Repair                        | <input type="checkbox"/> Sinus Problems      |
| <input type="checkbox"/> Chemical Dependency                            | <input type="checkbox"/> High Blood Pressure                  | <input type="checkbox"/> Special Diet        |
| <input type="checkbox"/> Chronic Diarrhea                               | <input type="checkbox"/> HIV/AIDS                             | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Circulatory Problems                           | <input type="checkbox"/> Low Blood Pressure                   | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Congenital Heart Lesions                       | <input type="checkbox"/> Mitral Valve Prolapse                | <input type="checkbox"/> Ulcer               |
| <input type="checkbox"/> Diabetes                                       | <input type="checkbox"/> Nervous Problems                     | <input type="checkbox"/> Venereal Disease    |

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia?  Yes  No

If so, what? \_\_\_\_\_

Have you ever responded adversely to medical or dental treatment?  Yes  No

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

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.)  Yes  No

Are you under the care of a physician?  Yes  No For what conditions? \_\_\_\_\_

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

(Women) Do you suspect that you are pregnant?  Yes  No Due date \_\_\_\_\_

Are you nursing?  Yes  No Taking birth control pills?  Yes  No

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

## CERTIFICATION

To the best of my knowledge, the information I have provided on this form is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

\_\_\_\_\_  
Signature of Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient

## MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment?  Yes  No

For what conditions? \_\_\_\_\_

Is the patient taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dentist Signature

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\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dentist Signature

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\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dentist Signature

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\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dentist Signature