PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ **Home Phone** _____

Cell Phone _____

Patient _____
Last Name First Name Preferred Name

Street Address _____ **City** _____ **State** _____ **Zip** _____

Sex ❑ **M** ❑ **F** **Age** _____ **Birthdate** _____ **Marital Status** _____ **SS#** _____

Employed By _____ **Occupation** _____

Business Address _____ **Business Phone** _____

Spouse Name _____ **SS#** _____

Employed By _____ **Occupation** _____

Business Address _____ **Business Phone** _____

Who is responsible for this account? _____

Relationship to patient _____

Name of Dental Insurance Co. _____ **Group Number** _____

Names and ages of children _____

_____

In case of emergency, who should be notified? _____ **Phone** _____

Whom may we thank for referring you? _____

Over for medical history

PHYSICIAN'S NAME_____ **DATE OF LAST PHYSICAL**_____

Please mark the following *only* if your answer is **"YES":**

Have you ever **become sick *from,* shown *an allergy to* or been *told not to take:***
- ❑ Antibiotics (penicillin, etc.)
- ❑ Codeine
- ❑ Novocaine or other dental anesthetics
- ❑ Other drugs or medicines_____

_____

Are you ***now*** taking or using medicines for:
- ❑ Diabetes (pills or 'shots')
- ❑ Nerves (tranquilizers)
- ❑ Sleeping
- ❑ Heart or blood pressure
- ❑ Blood (liver or iron pills, etc.)
- ❑ Headaches
- ❑ Arthritis or rheumatism
- ❑ Allergies
- ❑ Thyroid condition

Are you ***now:***
- ❑ Pregnant
- ❑ On a prescribed diet
- ❑ Using hormones (including birth control pills)
- ❑ Using blood thinners
- ❑ Using Dilantin
- ❑ Using Herbs

**** please list all medications taken regularly***

_____

_____

Have you **ever** had ***any*** of the following:
- ❑ Heart disease
- ❑ Shortness of breath without exercise or when lying down
- ❑ Swelling of ankles or feet
- ❑ Pain, pressure, or tight feeling in chest
- ❑ Heart attack
- ❑ Rheumatic fever
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Fainting spells, convulsions, epilepsy
- ❑ Frequent headaches (two or three a week)
- ❑ Nervous breakdown, psychotherapy
- ❑ Lung trouble (TB, emphysema)
- ❑ Asthma
- ❑ Hepatitis, liver disease, jaundice
- ❑ Arthritis, sore joints
- ❑ Diabetes
- ❑ Excessive bleeding
- ❑ Blood trouble, anemia, leukemia
- ❑ VD (syphilis, gonorrhea, herpes)
- ❑ HIV or "AIDS"
- ❑ Immunosuppressive disorders
- ❑ Heart murmur
- ❑ Mitral valve prolapse
- ❑ Pacemaker
- ❑ Artificial heart valves
- ❑ Artificial joints
- ❑ Hemophilia
- ❑ Recent weight loss
- ❑ Chronic diarrhea
- ❑ Ulcer
- ❑ Radiation or chemotherapy treatment
- ❑ Cancer
- ❑ Stroke
- ❑ Neurological disorders

Are you under the care of a physician? yes___no___For what conditions?_____

_____

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 which I am entitled. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I have made in completion of this form.

Date_____ Signature_____