

PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____

Home Phone _____

Cell Phone _____

Email _____

Child's _____
Last Name First Name Preferred Name

Child's Address _____ City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____ School _____

Father _____ SS# _____

Father's employer _____ Phone _____ Occupation _____

Father's Address _____ Phone _____

Mother _____ SS# _____

Mother's employer _____ Phone _____ Occupation _____

Mother's Address _____ Phone _____

Who is responsible for this account? _____

Relationship to patient _____

Name of Dental Insurance Co. _____ Group Number _____

Names and ages of brothers & sisters _____

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

Whom may we thank for referring you? _____

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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
- Depression

Are you **now:**

- Pregnant
- On a prescribed diet
- Using hormones (including birth control pills)
- Using blood thinners
- Using Dilantin
- Using Herbs

** please list all daily medications*

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, seizures
- 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 _____