Office I.D. #_____

PATIENT REGISTRATION

Patient's Name _____ (Last) _____ (First) _____ (M.I.)

S.S. # _____

Date of Birth _____

Marital Status _____ Age _____

Home Address _____ (Number) _____ (Street)

Home Phone # _____

Cell Phone # _____

City/State _____ Zip Code _____

Work Phone # _____

Physician's Name _____ Referring Dentist _____

Orthodontist _____

Have you or your family been seen here previously? _____

Date _____

In Case of Emergency Notify _____ (not spouse) Home Phone# _____ Work Phone # _____

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

Name _____ (Last) _____ (First) _____ (M.I.) _____ (Relationship)

S. S. # _____

Mailing Address _____ Zip Code _____

Name of Insured _____ DOB: _____ S.S.# _____

Employer _____ Business Phone # _____

Name of Dental Insurance Company _____

MEDICAL HISTORY

Reason for Visit Here _____

How long has it troubled you? _____

Are you under a Physician's care? Yes _____ No _____

If Yes, for What? _____

What operations have you had? _____

What drugs or medications have you taken in the past two years?

Height _____ Weight _____

Do you have a history of:	YES	NO
Requiring antibiotics prior to dental work?		
Allergies to Food or Drugs?		
Do you take any medication?		
Reaction to Local or General Anesthetic (you or your family)		
Do you take any Herbal Supplements		
Cancer, Chemotherapy, Radiation treatment		
Are you or have you taken any Bisphosphonate drugs: (ie: Aredia, Pamidronate, Zolendronate, Zometa, Fosamax, Reclast)		
Heart Disease, Heart Murmur, Congenital Heart Defect		
Rheumatic Fever, Mitral Valve Prolapse		
Heart Attack, Heart Surgery, Heart Medicine		
Chest Pain, Angina, Shortness of breath		
Cardiac Pacemaker		
Stroke/Cerebrovascular Accident		
High/Low Blood Pressure		
Lung Disease, Asthma, Pneumonia, Tuberculosis		
Blood Disease, Blood transfusion, Sickle Cell Disease, Bleeding Tendency, Anemia (you or your family)		
Anticoagulants (Blood Thinners)		
Do you smoke or chew tobacco		
Recent unintentional weight loss or gain		
Diabetes (you or your family)		
Ulcers, Intestinal Bleeding, Colitis, Gastric Reflux		
Kidney or Bladder Disease		
Liver Disease, Hepatitis, Jaundice		
HIV Exposure, AIDS		
Epilepsy, Convulsions, Seizures		
Thyroid Disease (Goiter) or Thyroid Medication		
Glaucoma, Eye Surgery		
Implants anywhere in your body		
Pain in the region of the ear		

	YES	NO
Popping, Clicking, Locking of the Jaw		
Drug Abuse, Alcoholism, or Emotional Disorder		
Venereal Disease		
Are you using birth control pills, patch or injections?		
Are you pregnant?		
How many months?		

Date of Last Menstrual Period

Any other disease or problem which your Doctor should know about before proceeding with treatment.

Please explain _____

I acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____

Signature Date

Summary (Dr. use) _____

_____ ASA Class: _____

Dr. Signature _____ Date _____