

**PATIENT REGISTRATION AND MEDICAL HISTORY**

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

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

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

Sex:  M  F Age \_\_\_\_\_ Birth date \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Spouse Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

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

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

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

Name of Medical 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 \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

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

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Heart Problems                    | <input type="checkbox"/> Epilepsy                             | <input type="checkbox"/> Special Diet                          |
| <input type="checkbox"/> High Blood Pressure               | <input type="checkbox"/> Headaches                            | <input type="checkbox"/> Swollen Neck Glands                   |
| <input type="checkbox"/> Low Blood Pressure                | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease | <input type="checkbox"/> Rheumatic Fever                       |
| <input type="checkbox"/> Circulatory Problems              | <input type="checkbox"/> Cancer                               | <input type="checkbox"/> Sinus Problems                        |
| <input type="checkbox"/> Nervous Problems                  | <input type="checkbox"/> Psychiatric Care                     | <input type="checkbox"/> "A.I.D.S." or Other                   |
| <input type="checkbox"/> Radiation Treatment               | <input type="checkbox"/> Chronic Diarrhea                     | <input type="checkbox"/> Immunosuppressive Disorders           |
| <input type="checkbox"/> Artificial Heart Valves or Joints | <input type="checkbox"/> Allergies to Anesthetics             | <input type="checkbox"/> Stroke <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Recent Weight Loss                | <input type="checkbox"/> Allergies to Medicine or Drugs       | <input type="checkbox"/> Venereal Disease                      |
| <input type="checkbox"/> Back Problems                     | <input type="checkbox"/> General Allergies                    | <input type="checkbox"/> Chemical Dependency                   |
| <input type="checkbox"/> Diabetes                          | <input type="checkbox"/> Blood Disease                        | <input type="checkbox"/> Hemophilia                            |
| <input type="checkbox"/> Respiratory Disease               | <input type="checkbox"/> Arthritis                            |  |

Do you have any allergies or have you ever had an adverse reaction to any medication? \_\_\_\_\_ If so, what \_\_\_\_\_

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

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

(Women) Do you suspect that you are pregnant?  Yes  No 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.

Date \_\_\_\_\_ Signature \_\_\_\_\_