



PATIENT REGISTRATION

PATIENT INFORMATION

FIRST NAME	MIDDLE INITIAL	LAST NAME	TODAY'S DATE
EMAIL			
ADDRESS		APT#	BIRTHDATE
CITY	STATE	ZIP	<input type="checkbox"/> MALE <input type="checkbox"/> MARRIED <input type="checkbox"/> FEMALE <input type="checkbox"/> SINGLE
HOME PHONE <input type="checkbox"/> PREFERRED	CELL PHONE <input type="checkbox"/> PREFERRED	WORK PHONE <input type="checkbox"/> PREFERRED	SOCIAL SECURITY NUMBER

IF PATIENT IS A MINOR, PROVIDE THE FOLLOWING	PARENT/LEGAL GUARDIAN FIRST NAME LAST NAME	RELATIONSHIP TO PATIENT <input type="checkbox"/> PARENT <input type="checkbox"/> GRANDPARENT <input type="checkbox"/> OTHER <input type="checkbox"/> LEGAL GUARDIAN		
	EMAIL ADDRESS			
	ADDRESS <input type="checkbox"/> SAME AS ABOVE	CITY	STATE	ZIP
HOME PHONE <input type="checkbox"/> PREFERRED	CELL PHONE <input type="checkbox"/> PREFERRED	WORK PHONE <input type="checkbox"/> PREFERRED	SOCIAL SECURITY NUMBER	
Pharmacy Address & Tel#				

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT PERSON	PHONE NUMBER	RELATIONSHIP
NAME OF CLOSEST RELATIVE NOT LIVING WITH YOU	PHONE NUMBER	RELATIONSHIP

THE BIGGEST COMPLIMENT OUR PATIENTS CAN GIVE US IS THE REFERRAL OF FAMILY & FRIENDS

WHOM MAY WE THANK FOR REFERRING YOU?	ARE THEY A PATIENT HERE?	<input type="checkbox"/> YES <input type="checkbox"/> NO - CHOOSE BELOW
HOW DID YOU HEAR ABOUT OUR OFFICE?		
<input type="checkbox"/> OUR WEBSITE	<input type="checkbox"/> BUILDING SIGN	<input type="checkbox"/> YOUR EMPLOYER
<input type="checkbox"/> INSURANCE COMPANY	<input type="checkbox"/> ONLINE SEARCH	<input type="checkbox"/> MAILER/UNION HALL <input type="checkbox"/> SOCIAL MEDIA <input type="checkbox"/> PUBLIC EVENT

IF YOU HAVE DENTAL INSURANCE, PLEASE PROVIDE THE FOLLOWING & YOUR INSURANCE CARD

PRIMARY CARRIER		SECONDARY CARRIER	
INSURANCE COMPANY NAME	INSURANCE PHONE	INSURANCE COMPANY NAME	INSURANCE PHONE
EMPLOYER NAME	EMPLOYER PHONE	EMPLOYER NAME	EMPLOYER PHONE
PRIMARY INSURED NAME		PRIMARY INSURED NAME	
BIRTH DATE	RELATIONSHIP TO PATIENT	BIRTH DATE	RELATIONSHIP TO PATIENT
INSURED INSURANCE I.D. NUMBER	GROUP NUMBER	INSURED INSURANCE I.D. NUMBER	GROUP NUMBER



MEDICAL HISTORY

The following questions are for your benefit and assure that any dental treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care. Please answer each question.

1. Have you taken any medication or drugs during the past two years? YES NO
2. Are you currently taking any medication, drugs, pills or herbal remedies, including dosages of aspirin? YES NO
If YES, please list name and dosage:

3. Are you sensitive or allergic to any substance(s) or medication? YES NO
If YES, please check all that apply Aspirin Codeine Darvon Demerol Erythromycin Latex Nitrous Oxide
 Penicillin Percodan Sulfa Drugs Tetracycline Valium Vicodin Metals Other
4. Have you ever taken prescription medications for weight loss (diet pills)? YES NO
If YES, did you take any of the following: Fen-Phen Pondimin Redux Other
5. Have you ever taken osteoporosis or bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? YES NO
6. Have you been a patient in the hospital during the past five years? YES NO
7. Have you ever had a serious injury to your head or mouth? YES NO
8. Have you ever been told to take a pre-medication prior to dental treatment? YES NO
9. Is there anything else about having dental treatment that you would like us to know? YES NO
Please explain :

10. Have you lost or gained more than 10 pounds in the past year? YES NO
11. Do you have, or have you had any disease, condition, or problem not listed? YES NO
If, please list:

12. Indicate which of the following you have had, or have at present. Check "YES" or "NO" to each item.
NOTE: Certain medical conditions may require a medical consultation with your primary care physician prior to the start of any dental treatment.

	YES	NO		YES	NO		YES	NO
A.I.D.S./H.I.V. Positive	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Diet (Special/Restricted)	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve/Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric/Psychological Care	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease or Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Allergy/Hives	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, Tumors, Growths	<input type="checkbox"/>	<input type="checkbox"/>	Head Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack, Disease, Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems/Disease	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A B C (CIRCLE WHICH ONE)	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Cold Sores/Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infection or Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other (Please list below)	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>			

WOMEN

14. Are you pregnant or think you could be pregnant?..... YES _____ Months NO Are you currently nursing? YES NO

15. Do you use birth control prescriptions? YES NO

16. Do you have any problems associated with your menstrual period? YES NO

I have answered all questions to the best of my knowledge. Should further information be needed, I grant permission to ask my respective healthcare providers or agencies, who may release information to you. I will notify the dentist of any changes in my health or medication.

PATIENT SIGNATURE or GUARDIAN _____ DATE _____ DENTIST REVIEW SIGNATURE, DATE _____