Patient Registration and Medical History

Patient		Preferred Name
Last Name	First Name Initial City	
Moiling Address	City	State Zip
Mailing Address	Marital Status	Home Phone
Male/Female Bittidate	Marital Status Home Phone Occupation	
Pusiness Address	Bus. Phone	
Constant Norma		Rirthdate
Spouse/Parent Name	Birthdate Occupation	
Spouse/Parent Employed by	:	Rus Phone
Business Address		Bus. Phone
Person responsible for this according	ountRelationship to Patient Spouse/Parent Social Security #	
Social Security #	Spouse/Parent Sc	Crair Security #
Name of Dental Insurance Com	pany	Group #
Person to be notified in case of e	emergency	Phone
Physician's Name	Date	e of Last Physical
Have you ever had any of the fo	ollowing? (Circle any that apply):	
Heart Murmur	Allergies, general	Headaches
Mitral Valve Prolapse	Blood Disease	Heart Problem
Pacemaker	Blood Pressure Problem	(Type
Replacement Heart Valves	(High)(Low)	Hepatitis, Jaundice, Liver Disease
Rheumatic Fever	Cancer (Type)	(A)(B)(Other)
Provided to the provided the pr	(Radiation - year)	Nervous Problem
Arthritis (Type)	Chemical Dependency	Respiratory Disease
Artificial Joints (Year)		Sinus Problem
Artificial Joint Infection	Circulatory Problem	Stroke
Diabetes	Cold Sores	Venereal Disease
Immune System Supression	Epilepsy	Venereal Disease
TY	and to take an antibiotic prior t	a dantal trantment?
	need to take an antibiotic prior t	
List any medicine, drug or subst	ance to which you have had an ac	Iverse or allergic reaction
T in the second of the second	inal and antal treatment in the nor	.4
List any adverse reaction to medical or dental treatment in the past		
List any medication (prescription or non-prescription) that you are taking at this time		
	1 i - i - i - i - i - i - i - i - i	
List any conditions for which a physician is treating you		
If patient is a child, what is his/her weight?		
(Women) Do you suspect that you are pregnant? Are you nursing? Is there anything else we should know about your medical history?		
is there anything else we should	know about your medical history	
The above information is accurat	e and complete to the best of my	knowledge and is only for use in my
		which I am entitled. I will not hold my
	f responsible for any errors or om	
completion of this form.	responsible for any errors or one	assion that I have made in the
completion of this form.	Signature	Data
Minou/Child Concert	ognature	Date
Minor/Child Consent		de beneficione de la company
I, being the parent/guardian ofdo hereby request and authorize		
41	Name of minor/child	digital and the second
the dental staff to perform necessary dental services for my child, including, but not limited to, X-rays and		
administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the		
actual appointment when the treatment is rendered.		
Signature of Insured/Guardian Date		