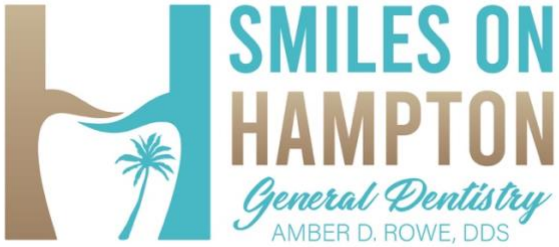

PATIENT REGISTRATION AND MEDICAL HISTORY

(Please Print)

Date _____

Patient Name _____
Last First Initial Preferred Name

Home Phone _____ Office Phone _____

Cell Phone _____ Other _____

Mailing Address Street _____

_____
City State Zip

Email Address _____

Sex: Male _____ Female _____ Prefer Not to Say _____ Birthdate _____ Age _____

Single _____ Married _____ Widowed _____ Separated _____ Divorced _____

Employed By _____ Occupation _____

Business Address _____

Spouse Name _____ Spouse Birthdate _____

Spouse Employer _____ Occupation _____

Spouse Business Address _____ Spouse Business Phone _____

Who is Responsible For This Account? _____ Relationship to Patient _____

Social Security # _____ Spouse's SSN _____

Name of Dental Insurance Company _____ Group # _____

In Case of Emergency, Who Should Be Notified? _____ Phone _____

Whom May we Thank for Referring You? _____

MEDICAL HISTORY

Physician's Name _____ Office # _____

Date of Last Physical Exam _____

Have You Ever Had Any of The Following? (Check All That Apply)

_____Heart Problems
_____High Blood Pressure
_____Low Blood Pressure
_____Circulatory Problems
_____Nervous System Problems
_____Radiation or Chemo Treatment
_____Artificial Heart Valve or Joints
_____Recent Weight Loss
_____Back or Neck Problems
_____Diabetes
_____Respiratory Disease
_____Osteoporosis Medication
_____Aspirin or Other Blood Thinner
_____Epilepsy
_____Headaches
_____Hepatitis
_____Liver Disease
_____Jaundice
_____Psychiatric Care
_____Chronic Diarrhea
_____Allergies to Anesthetics
_____Allergies to Medicines
_____General Allergies
_____Blood Disease
_____Arthritis
_____Special Diet
_____Swollen Neck Glands
_____Rheumatic Fever
_____Sinus Problems
_____AIDS or other Immunosuppressive Disorder
_____Stroke
_____Ulcer
_____Venereal Disease
_____Chemical Dependency
_____Hemophilia
_____Cancer

Do you have any drug allergies, or have you ever had an adverse reaction to any medication? _____

If so, please elaborate _____

Have you ever responded adversely to medical or dental treatment? _____

Are you taking any medication at this time? _____

If so, please list all medications: _____

Are you under the care of a physician? Yes _____ No _____

For what conditions? _____

If patient is under 18, what is their weight? _____

(Woman) Do you suspect 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 which I am entitled. I will not hold my dentist or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date _____