PATIENT REGISTRATION AND MEDICAL HISTORY

Patient_____ Date_____
Last Name *First* *Mid*
Address_____City_____State_____Zip_____

Home Phone:_____ Cell Phone:_____Sex: ☐ M ☐F ☐Single ☐Married

Date of Birth:_____Age_____Email Address:_____

PATIENT INFORMATION

Driver's license:_____

Social Security #:_____

Employed by:_____

Address:_____

Business Phone:_____

Occupation:_____

Dental Insurance:_____

Company:_____

Insurance Phone:_____

Group #_____

SPOUSE INFORMATION

Spouse Name:_____

Date of Birth:_____

Social Security #:_____

Employed by:_____

Address:_____

Business Phone:_____

Occupation:_____

Dental Insurance Company:_____

Insurance Phone:_____

Group #_____

Person Responsible for Account_____Relationship to patient_____

In case of emergency, who should be notified?_____Phone_____

Whom may we thank for referring you to our office?_____

INSURANCE INFORMATION

A dental insurance policy is a contract between your employer and the insurance company. Our professional services are rendered and charged directly to the patient's account and the patient or person responsible for the account is responsible for payment of all fees incurred. For your convenience, we ask that you provide us with all necessary information regarding your insurance carrier and insurance policy including any updates and/or changes.

Medical / Dental History

Previous Dentist's Name:_____Address_____

Phone_____ Date of last dental visit:_____

Frequency of dental checkups: ☐Once a year ☐twice a year ☐only if problem exists ☐Never

Are you frightened of dental treatment? ☐ No ☐ Yes Have you had any facial or dental injury? ☐ No ☐ Yes

Explain: _____

Please check all that apply:

☐ Clenching teeth ☐ Thumb or Finger sucking ☐ Jaw joint soreness ☐ Ringing in the ears ☐ Grinding teeth
☐ Muscular soreness around head & neck ☐ Jaw joint clicking or popping ☐ Mouth breathing

Medical History

Physician's Name:_____Address:_____Phone_____

Heart Problems	☐ No ☐ Yes	Epilepsy	☐ No ☐ Yes	Special Diet	☐ No ☐ Yes
High Blood Pressure	☐ No ☐ Yes	Headaches	☐ No ☐ Yes	Swollen neck glands	☐ No ☐ Yes
Low Blood Pressure	☐ No ☐ Yes	Cancer	☐ No ☐ Yes	Chemical Dependency	☐ No ☐ Yes
Circulatory Problems	☐ No ☐ Yes	Psychiatric Care	☐ No ☐ Yes	Rheumatic Fever	☐ No ☐ Yes
Nervous Problems	☐ No ☐ Yes	Chronic Diarrhea	☐ No ☐ Yes	HIV/AIDS	☐ No ☐ Yes
Radiation Treatment	☐ No ☐ Yes	Allergies to Anesthetics	☐ No ☐ Yes	Stroke	☐ No ☐ Yes
Recent Wt. Loss	☐ No ☐ Yes	General Allergies	☐ No ☐ Yes	Ulcer	☐ No ☐ Yes
Back Problems	☐ No ☐ Yes	Blood Disease	☐ No ☐ Yes	Venereal Disease	☐ No ☐ Yes
Diabetes	☐ No ☐ Yes	Arthritis	☐ No ☐ Yes	Hemophilia	☐ No ☐ Yes
Respiratory Disease	☐ No ☐ Yes	Allergy to Medicine/Drugs	☐ No ☐ Yes	Sinus Problems	☐ No ☐ Yes
Artificial heart valves	☐ No ☐ Yes	Hepititis,Jaundice/Liver	☐ No ☐ Yes	Other	☐ No ☐ Yes

Do you have any drug allergies or have had any adverse reaction to any medication?_____If Yes, What_____

_____

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

Are you taking any medication at this time?_____ If so, please list_____

Are you under the care of physician? ☐ Yes ☐ No For what condition? _____

(Woman) 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?_____

I give consent for treatment.

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.

Signature_____ Date_____