Welcome to our dental office...

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Full Name ______________________ Date of Birth ____/____/____

Parents' Full Name, if Child ______________________ Spouse's Full Name ______________________ Sex M

Address ______________________ Apt# ______ City/State ______________________ Zip ________ Tel#(____) ________

SS# ______________ Employer's Name ______________________ Occupation ______________

Work#(____) ______________ Ext. ______ Employer's Address ______________________

City/State ______________ Zip ________ Referred by ______________ Phisician's Name ______________

Date of Last Physical Exam ____/____/____ Reason for Last Physical Exam ______________________

INSURANCE SUBSCRIBER'S INFORMATION - Primary Dental Insurance

Name of Dental Insurance ______________________ Subsriber's Full Name ______________________

Subscriber's D.O.B. ____/____/____ Subscriber's Relationship to Patient ______________ Subscriber's SS# ______________

Subscriber's Employer's Name ______________________ Occupation ______________ Work#(____) ______________

Employer's Address ______________________ City/State ______________ Zip ________

INSURANCE SUBSCRIBER'S INFORMATION - Secondary Dental Insurance

Name of Dental Insurance ______________________ Subsriber's Full Name ______________________

Subscriber's D.O.B. ____/____/____ Subscriber's Relationship to Patient ______________ Subscriber's SS# ______________

Subscriber's Employer's Name ______________________ Occupation ______________ Work#(____) ______________

MEDICAL HISTORY- Please answer each question.

	Yes	No
Poor Health	[ ]	[ ]
Recent Illness	[ ]	[ ]
Recent Cough or Cold	[ ]	[ ]
Nose Obstruction	[ ]	[ ]
Heart or Chest Pain	[ ]	[ ]
Heart Murmur	[ ]	[ ]
Heart Trouble	[ ]	[ ]
Rheumatic Fever	[ ]	[ ]
Mitral Valve Prolapse	[ ]	[ ]
High Blood Pressure	[ ]	[ ]
Facial X-Ray Treatment	[ ]	[ ]

	Yes	No
Hepatitis	[ ]	[ ]
Herpes	[ ]	[ ]
Diabetes	[ ]	[ ]
Cortisone or ACTH	[ ]	[ ]
Kidney Disease	[ ]	[ ]
Liver Disease	[ ]	[ ]
Lung Disease	[ ]	[ ]
Asthma	[ ]	[ ]
Bronchitis	[ ]	[ ]
Convulsions	[ ]	[ ]
Bleeding Tendency	[ ]	[ ]

	Yes	No
Allergy to:	[ ]	[ ]
Penicillin	[ ]	[ ]
Sulfa	[ ]	[ ]
Codeine	[ ]	[ ]
Aspirin	[ ]	[ ]
Barbiturates (Sleeping Pills)	[ ]	[ ]
Other Drugs	[ ]	[ ]
Anemia	[ ]	[ ]
HIV Positive	[ ]	[ ]
AIDS	[ ]	[ ]
Frequent Swollen Ankles.	[ ]	[ ]

	Yes	No
Must you sleep with your head on more than one pillow?	[ ]	[ ]
Have you ever been put to sleep for an operation?	[ ]	[ ]
Are you pregnant?	[ ]	[ ]
Are you under the care of a physician?	[ ]	[ ]
Are you now taking medicine of any kind?	[ ]	[ ]
have you ever responded unfavorably to medical or dental care?	[ ]	[ ]
Do you get short of breath after a little exertion?	[ ]	[ ]
Have you been hospitalized within the last five years?	[ ]	[ ]

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______________________ ____/____/____ ______________________ ____/____/____

Patient's Signature (Parent's, if child) Date Signed History Chart Reviewed by Date Signed