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Patient Registration and Health History

Patient Name: _____
Last First MI Preferred Name

Address: _____
Street City State Zip Code

Title: _____ Gender: _____ Male _____ Female Family Status: _____ Married _____ Single _____ Child _____ Other

Birth Date: _____ SS#: _____ Email: _____

Phone: _____
Home Cell Work

Best way to reach you? _____ Home _____ Cell _____ E-mail _____ Texting _____ Work.

Employment Information

The following is for: _____ Patient _____ Person responsible for payment

Employer Name: _____

Address: _____
Street City State Zip Code

How did you hear about our office? _____

Person to contact in case of emergency? _____
Name Phone

Insurance Information

Name of Insured: _____

Insured's Birth Date: _____ ID#: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Employer Address: _____
Street City State Zip Code

Patient's Relationship to Insured: _____ Self _____ Spouse _____ Child _____ Other

Insurance Plan Name: _____

Insurance Address: _____
Street City State Zip Code

Medical/Dental History

When was your last dental visit? _____

When was the last time you had complete dental x-rays taken? _____

Are you having any dental problems at this time? _____

Do your gums bleed when brushing or flossing? _____ Do you have a bad taste or bad breath? _____

Do you like the way your teeth look and feel? What would you change? _____

Who is your Physician? _____

Name Address

Have you been under the care of a medical doctor during the past two years? _____

If yes, for what reason? _____

Are you taking medicine or drugs? ___yes ___ no

If yes, please list all medications.

Are you allergic to penicillin? (i.e. itching, rash, swelling of hands, feet or eyes?) ___ yes ___ no

Any other allergies? _____

Are you a smoker? ___ yes ___ no

Women: Are you pregnant? ___ yes ___ no

Please check any of the following which you have had or have at present:

- | | | |
|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Blood Thinner | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Growths |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> MVP | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Sulfa Allergy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Tumors | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Any other conditions not listed | _____ | |

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I have any change in my health, I will inform the doctor at the next appointment without fail.

I hereby authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that prior to treatment, full explanation of the procedure (s) involved will be given by the doctor and/or staff. I agree to pay for all services rendered by this office.

Signature: _____ **Date:** _____