PATIENT REGISTRATION AND MEDICAL HISTORY

Date________________ (Please Print) Home# ______________Cell#________________

Patient____
Last Name First Name Initial Preferred Name

Street Address____City______________State______ZIP________

Social Security#_____________________ **(FOR INSURANCE ONLY)** Single____ Married____ Widowed____

Sex: M____ F____ Age______ Birth Date_______________ Separated____ Divorced_____

E-mail (for our office **ONLY** and will **NOT** be shared)_________________________________Occupation______________

Spouse Name____ Birth Date__________________

Spouse's Social Security#________________________
***Spouse ss# needed if dental insurance is in their name only. *We are out of network for all dental insurance companies.**

Name of Dental Insurance Company____ Please give card to front desk.

Whose name is insurance under?___________________________________ Relationship to patient________________

In case of emergency, who should be notified?_______________________________________ Phone#______________

Physician's Name____

Please check all that apply:

____Heart Problems/MVP ____Epilepsy/Fainting ____Arthritis

____High Blood Pressure ____Headaches ____Any transplant

____Low Blood Pressure ____ Joint Replacement ____Hepatitis

____Circulatory Problems ____Cancer/Radiation treatment ____TMJ Problems

____Nervous Problems ____Psychiatric Care ____HIV/A.I.D.S

____Artificial Heart valves ____Chronic Diarrhea/Ulcers ____Stroke

____Recent Weight Loss ____Diabetes ____Blood Disease

____Chemical Dependency ____Allergies to Medicine ____Pregnant/Nursing

____ Jaundice/Liver Disease ____General Allergies ____Back Problems

____Respiratory Disease ____**Bisphosphonate Drugs**
(Fosamax, Actonel, Boniva etc.)

Are you taking any medication?_____
(If so, please list below)

____
____
____
____
____
____
____
____
____

Do you have any drug allergies or any adverse reaction to any medication/ medical or dental treatment?____If so, what are they?

____

Are you supposed to premedicate before ALL dental appointments with an antibiotic (including cleaning appointments?)____

Are you under the care of a physician? _____yes _____no For what conditions?_______________________________

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors of omissions I have made on this form.

x_____________________ x____
Date Signature