

PATIENT REGISTRATION

Date _____

Mr. Mrs. Miss Ms. Dr.

Patient's Name _____ Nickname _____ Sex M F

Patient's Address _____ Home Phone _____
Street City Zip

Social Security Number _____ Birthdate _____ Cell Phone _____

Patient's Employer _____ Business Address _____

Occupation _____ Phone _____

Name of Spouse _____ Spouse's Employer / Occupation _____

DL # _____ Whom May We Thank for Referring You _____

Nearest Neighbor or Relative's Name, Address, and Phone No. _____

PLEASE COMPLETE THIS SECTION IF PATIENT IS A MINOR AND/OR RESPONSIBLE PARTY

Responsible Party's Complete Name _____ Social Security Number _____

Home Address _____ Phone (Home) _____ (Cell) _____
Street City Zip

DL# _____ Place of Employment _____ Occupation _____

Business Address _____ Phone (Business) _____
Street City Zip

MEDICAL HISTORY

General Health Excellent Good Fair Poor Height _____ Weight _____

Name and Address of Physician _____

Name and Address of Dentist _____

Last Complete Physical _____

Are You Taking Any Medication Now? Yes No Please List _____

Are You Allergic to: Penicillin Codeine Local Injected Anesthetics Latex Other: _____

Are You Subject to Prolonged Bleeding? Yes No

(Women) Are You Pregnant? Yes No Which Trimester? _____

Are You Nursing? Yes No

Have You Had Any Serious Trouble Associated With Previous Dental Treatment? Yes No Explain: _____

_____ Please complete the reverse side of this form

Have You Ever Been Diagnosed or Treated For:

- | | |
|---|--|
| Heart Disease..... | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Rheumatic Fever..... | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Heart Murmur | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Abnormal Blood Pressure..... | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Congenital Heart Lesions... .. | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Ulcers..... | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Tuberculosis..... | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Diabetes..... | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Endocrine (e.g., Thyroid)..... | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Autoimmune Disease..... | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Stroke/Neurological Disease..... | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Epilepsy/Seizures | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Syphilis, Gonorrhea, Sexually Transmitted Disease..... | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| AIDS, or HIV..... | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Pulmonary / Lung Disease..... | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Asthma..... | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Jaundice/Liver Disease/Hepatitis..... | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Sinus Trouble/Allergies/Hay Fever..... | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Arthritis..... | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Cancer..... | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Prosthetic Replacement (Hip, Shoulder, etc.)..... | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Have You Ever Had Radiation Therapy?..... | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Do You Have a Pacemaker / Implanted Electronic Device?..... | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Do You Use Recreational Drugs? (Cocaine, Marijuana)..... | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Any Other Serious Illness?..... | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Please List: | |

Signature: _____