PATIENT REGISTRATION AND MEDICAL HISTORY

PLEASE COMPLETE FORM IN ITS ENTIRETY AND RETURN TO RECEPTION

PLEASE PRINT CLEARLY AND NEATLY Date (M/D/Y) ____/____/____ Home Phone (_____)_____

Patient_____
Last Name First Name Middle Preferred Name

Address_____ City_____ State_____ Zip_____

Sex : Male Female Birth Date: (M/D/Y) ____/____/____ Marital Status: (Circle one) Single Married Widowed Divorced

Social Security #_____-_____-_____ Cell (_____)_____ Beeper (_____)_____

E-Mail Address_____ Fax Number (_____)_____

Employed By_____ Occupation_____

Business Address_____ Business Phone_____

Credit Card #_____ Expiration Date ____/____ (Circle One) Visa Master Discover AmEx

Spouse/Parent Name_____ Spouse/Parent Birth Date_____

Spouse/Parent Social Security #_____-_____-_____ Cell (_____)_____ Beeper (_____)_____

Spouse/Parent Employed by:_____ Occupation_____

Dental Insurance Company_____Group Number_____

Insurance Company Address_____

Employer Name_____ Address_____

Drivers License #_____ Emergency Contact _____

Who is responsible for this account?_____ Relationship to patient?_____

Whom may we thank for referring you?_____

Physician Name and Address _____ Date of last Physical (M/D/Y) ____/____/____

Have you ever had any of the following? (Please circle all that apply)

Y N AIDS/HIV	**Y N Epilepsy**	**Y N Migraine Headaches**	**Y N Surgical Pins or Plates**
Y N Allergies to Anesthetics	**Y N Excessive Bleeding**	**Y N Mitral Valve Prolapse**	**Y N Surgical Procedures**
Y N Allergies to Medicines	**Y N Eye Problems**	**Y N Multiple Sclerosis**	**Y N Thyroid Disease**
Y N Alzheimer's Disease	**Y N Glaucoma**	**Y N Nervous Problems**	**Y N Ulcer**
Y N Anemia	**Y N Heart Disease**	**Y N Osteoporosis**	**Y N Venereal Disease**
Y N Artificial Heart Valves	**Y N Heart Murmur**	**Y N Pre-medication**	**Y N Vertigo (Dizziness)**
Y N Arthritis	**Y N Hepatitis**	**Y N Psychiatric Condition**	**Y N Other:**_____
Y N Asthma	**Y N Hernia**	**Y N Radiation Treatment**	**Y N Other:**_____
Y N Back Problems	**Y N High Blood Pressure**	**Y N Recent Weight Loss**	**Y N Other:**_____
Y N Blood Disease	**Y N Kidney Disease**	**Y N Rheumatic Fever**	**Y N Other:**_____
Y N Cancer	**Y N Liver Disease**	**Y N Seasonal Allergies**	**Y N Other:**_____
Y N Chemical Dependency	**Y N Low Blood Pressure**	**Y N Sinus Problems**	**Y N Other:**_____
Y N Circulatory Problems	**Y N Lung Disease**	**Y N Special Diet**	**Y N Other:**_____
Y N Diabetes	**Y N Memory Loss**	**Y N Stroke**	**Y N Other:**_____

Do you have any drug allergies or have had any adverse reaction to any medication, or medical or dental treatment? **Y N**

If so, what? _____

Are you taking any medication at this time? **Y N** If so, what and why? _____

(Women) Do you suspect that you are pregnant? **Y N** Are you pregnant? **Y N** Are you nursing? **Y N**

Is there anything else we should know about your medical history? _____

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 (M/D/Y)** ____/____/____