

PATIENT REGISTRATION AND MEDICAL HISTORY

Patient _____ Dr. Mr. Mrs. Ms.
Last Name First Name Middle Initial

Street Address _____
City State Zip

Mailing Address if different _____

Email _____ Home Phone _____

Sex M F Age _____ Birthdate _____ Social Security Number _____

Employer _____ Occupation _____

Work Phone _____ Cell Phone _____

Spouse Name _____ Spouse Birthdate _____

Spouse Employed by _____ Occupation _____

Name of General Dentist _____

MEDICAL HISTORY

Have you ever had any of the following? (check boxes that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Angina | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> TMJ Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Bleeding Abnormality | <input type="checkbox"/> Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Blood Disease | when _____ | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> HIV <input type="checkbox"/> AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Latex Sensitivity / Allergy | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Ulcer |

Physicians's Name _____ Date of Last Physical _____

Do you premedicate with antibiotics for dental procedures Yes No _____

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia? Yes No

If so, what? _____

Are you taking medication at this time? Yes No If so, what? _____

Are you under the care of a physician? Yes No For what conditions? _____

(Women) Pregnant Yes No Due Date _____ Nursing Yes No

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

CERTIFICATION

To the best of my knowledge, the information on this form is complete and correct. I understand that it is my responsibility to inform my doctor if I have a change in health.

MINOR/CHILD CONSENT

I am the parent, guardian, or personal representative of _____
Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

EMERGENCY CONTACT INFORMATION

In case of emergency, who should be notified? _____ Phone _____

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that I am responsible for all fees and services rendered for treatment and I accept full financial responsibility for all charges for services or items provided to me or to the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

Signature of Patient _____ Date

Signature of Parent, Guardian or Personal Representative _____ Relationship to Patient
if patient is a minor

MEDICAL HISTORY UPDATE

Have there been any changes in the patient's health since the last dental appointment? Yes No

For what conditions? _____

Is the patient taking any new medications? _____ If so, what? _____

Date _____ Patient Signature

Date _____ Dentist Signature

MEDICAL HISTORY UPDATE

Have there been any changes in the patient's health since the last dental appointment? Yes No

For what conditions? _____

Is the patient taking any new medications? _____ If so, what? _____

Date _____ Patient Signature

Date _____ Dentist Signature

**Please complete this form if you are covered by
Dental Insurance**

Primary Carrier _____

Group Number _____

Employer _____

Subscriber Name _____

Subscriber SS# or ID# _____

Subscriber Birth Date _____

Relationship to Patient _____

Secondary Carrier _____

Group Number _____

Employer _____

Subscriber Name _____

Subscriber SS# or ID# _____

Subscriber Birth Date _____

Relationship to Patient _____