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

reviewed by ______________________

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

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

Physicians's Name ______________________ Date of Last Physical ______________

Are you required to take antibiotics for all dental procedures? ❑ Yes ❑ No ______________

Do you have any drug allergies or have you ever had an adverse reaction to any medication? ❑ 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? ______________

____

over

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 if patient is a minor

______________ Relationship to Patient

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