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