TIME 09:52 AM DATE 6/2/2015

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

deceased

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Medical History (Copy)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around you mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question	Answer	
Are you under a physician's care?	○ Yes ○ No	If yes
Have you ever been hospitalied or had a major operation?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you use tobacco?	○ Yes ○ No	If yes
Do you use controlled substances?	○ Yes ○ No	If yes
Have you EVER taken medication for osteoporosis or bone cancer?	○ Yes ○ No	If yes
Have you taken a blood thinner in the last 5 days?	○ Yes ○ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking Oral Contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Latex
☐ Epiephrine ☐ Sulfa

OTHER? ○ Yes ○ No If yes

General Health History: Do you have, or have you had, any of the following?

Cardiaovascular

High Blood Pressure	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Pacemaker	○ Yes ○ No	Angina/Chest Pains	○ Yes ○ No
Irregular Heartbeat	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Heart Trouble	○ Yes ○ No	Stroke	○ Yes ○ No

Pulmonary

Asthma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Tuberculosis	○ Yes ○ No	Emphysema	○ Yes ○ No
Breathing Problems	○ Yes ○ No						

Hemetology

HIV Positive	○ Yes ○ No	Anemia	○ Yes ○ No	Blood Disease	○ Yes ○ No	Hepatitis A	○ Yes ○ No
Hepatitis B or C	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Blood Thinner	○ Yes ○ No		

Metabolic

Diabetes	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Liver Disease	○ Yes ○ No	Yellow Jaundice	○ Yes ○ No
Thyroid Disease	○ Yes ○ No	Dialysis	○ Yes ○ No	Hypoglycemia	○ Yes ○ No		

Cancer/Radiation/Chemotherapy

Cancer	○ Yes ○ No	Radiation Treatment	○ Yes ○ No	Chemotherapy	○ Yes ○ No	Tumors or Growths	○ Yes ○ No

Pre-Medication

Artificial Joint	○ Yes ○ No	Artificial Heart Valve	○ Yes ○ No	Congenital Heart Disorder	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Scarlet Fever	○ Yes ○ No						

Misc:

Psychiatric Care	○ Yes ○ No	Alzheimer's Disease	○ Yes ○ No	Cortisone Medication	○ Yes ○ No	Rheumatism	○ Yes ○ No
Fainting/ Dizziness	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Epilepsy/Siezures	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Ulcers	○ Yes ○ No	Sinus Trouble	○ Yes ○ No				

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: