

PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ (PLEASE PRINT) Home Phone (____) _____

Patient _____
 Last Name First Name Middle Initial Preferred Name

Street Address _____ City _____ State _____ Zip _____

E-mail _____ Cell Phone (____) _____

Sex ☐ M ☐ F Age _____ Birthdate _____
☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years

Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

Spouse/Parent Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

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

Social Security # _____ Spouse/Parent's Social Security # _____

Name of Dental Insurance Company _____ Group Number _____

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

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____

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

- | | | |
|---|---|--|
| ☐ Allergies | ☐ Epilepsy | ☐ Pacemaker |
| ☐ Arthritis | ☐ Headaches | ☐ Psychiatric Care |
| ☐ Artificial Heart Valves or Joints, Screws, etc | ☐ Heart Murmur | ☐ Radiation Treatment |
| ☐ Back Problems | ☐ Heart Problems | ☐ Recent Weight Loss |
| ☐ Bleeding Abnormally | ☐ Hemophilia | ☐ Respiratory Disease |
| ☐ Blood Disease | ☐ Hepatitis, Jaundice or Liver Disease | ☐ Rheumatic Fever |
| ☐ Cancer | ☐ Hernia Repair | ☐ Sinus Problems |
| ☐ Chemical Dependency | ☐ High Blood Pressure | ☐ Special Diet |
| ☐ Chronic Diarrhea | ☐ HIV/AIDS | ☐ Stroke |
| ☐ Circulatory Problems | ☐ Low Blood Pressure | ☐ Swollen Neck Glands |
| ☐ Congenital Heart Lesions | ☐ Mitral Valve Prolapse | ☐ Ulcer |
| ☐ Diabetes | ☐ Nervous Problems | ☐ Venereal Disease |

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

If so, what? _____

Have you ever responded adversely to medical or dental treatment? ☐ Yes ☐ No

Are you taking any medication at this time? _____ If so, what? _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) ☐ Yes ☐ No

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

If patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Due date _____

Are you nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

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

CERTIFICATION

To the best of my knowledge, the information I have provided on this form is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Parent, Guardian or Personal Representative

Date

Please print name of Parent, Guardian or Personal Representative

Relationship to Patient

MEDICAL HISTORY UPDATE

Has there been any change 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

Has there been any change 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

Has there been any change 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

Has there been any change 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