Patient Registration and Medical History

Cell Phone: ____________________ Work Ph:___________________ Home Ph: ______________________

Patient name: (Last)_________________________(First)______________________(MI)_______(Preferred name)______________

Mailing Address:____City:___________________State________Zip_______________

Email Address:____

Sex: M__F__ Age:_____ Birthdate:_____________________ Single___Married___Widowed___Separated___Divorced_____

Employed by:____ Occupation___________________________________

Spouse Name: ____ Spouse DOB:_________________Spouse Ph#:_______________

Spouse Employed by:__________________________________ Occupation:____

Who is responsible for this account: _______________________________ Relationship to patient:________________________

Social Security #__________________________________ Spouse's Social Security #_____________________________________

Name of Dental Insurance Company _____________________________________ Group #_________________________________

In case of emergency, who should be notified?________________________________Phone__________________________________

Whom may we thank for referring you?____

MEDICAL HISTORY

Are you presently under the care of a physician? If so please explain. ____

Have you ever been told to take an antibiotic before dental treatment before?____

Please list any allergies: __________________________________Are you currently pregnant? _________ Nursing? ____________

Dental concerns today? (Pain) (Appearance)(Cavities)(Losing teeth)(Gum Disease)(Oral Cancer)(Other)_______________________

PLEASE LIST CURRENT MEDICATIONS (prescription, over the counter, & supplements):

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Do you have or have you ever had any of the following? (check all that apply):

- ☐ Heart problems: _________________
- ☐ High/low blood pressure
- ☐ Circulatory problems
- ☐ Nervous problems
- ☐ Radiation treatment
- ☐ Artificial heart valve
- ☐ Artificial joints________
- ☐ Anemia
- ☐ Diabetes (T1 or T2)
- ☐ Insulin Resistance
- ☐ Stomach ulcers
- ☐ Acid Reflux
- ☐ Glaucoma
- ☐ Stroke
- ☐ Heart murmur
- ☐ Dental Anxiety
- ☐ Psychiatric treatment
- ☐ Epilepsy
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Back problems
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Hepatitis
- ☐ Cancer : _____________
- ☐ Thyroid problems
- ☐ Fainting or dizziness
- ☐ Skin problems
- ☐ Arthritis
- ☐ TMJ
- ☐ HIV/AIDS
- ☐ STD/Herpes
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Implanted device
- ☐ CPAP
- ☐ Lung Disease
- ☐ Smoking/tobacco use
- ☐ E-cigarettes/vaping
- ☐ ______________________
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Signature ____ **Date** ____