

# PATIENT REGISTRATION AND HEALTH HISTORY

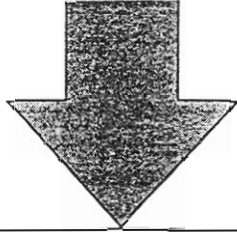
PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION



DATE				<b>1</b>
NAME				
SPOUSE				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.				
BIRTHDATE	AGE	MALE	FEMALE	
MARRIED	SINGLE	DIVORCED	WIDOWED	
SOCIAL SECURITY NO.				
DATE				
NAME				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.				
BIRTHDATE	AGE	MALE	FEMALE	
SCHOOL		GRADE		
SOCIAL SECURITY NO.				
IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO				



DENTAL INSURANCE		<b>2</b>
<b>PRIMARY CARRIER</b>		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYEE		
DATE OF BIRTH	DATE EMPLOYED	
UNION OR LOCAL NO.		
EMPLOYEE NO.		
EMPLOYEE SOCIAL SECURITY NO.		
<b>SECONDARY CARRIER</b>		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYEE		
DATE OF BIRTH	DATE EMPLOYED	
UNION OR LOCAL NO.		
EMPLOYEE NO.		
EMPLOYEE SOCIAL SECURITY NO.		



ACCOUNT INFORMATION		<b>4</b>
<b>PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT</b>		
NAME		
RELATIONSHIP TO PATIENT		
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
<b>YOU</b>		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS	CITY	
BUSINESS PHONE NO.	EXT.	
<b>YOUR SPOUSE</b>		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS	CITY	
BUSINESS PHONE NO.	EXT.	



GETTING TO KNOW YOU		<b>3</b>
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:	RELATIONSHIP:	
REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

**MEDICAL HISTORY**

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

Are you under a physician's care now?  Yes  No  N/A \_\_\_\_\_

Have you ever been hospitalized or had a major operation?  Yes  No  N/A \_\_\_\_\_

Have you ever had a serious head or neck injury?  Yes  No  N/A \_\_\_\_\_

Are you taking any medications, pills, or drugs?  Yes  No  N/A \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux?  Yes  No  N/A \_\_\_\_\_

Do you use tobacco?  Yes  No  N/A \_\_\_\_\_

Are you on a special diet?  Yes  No  N/A \_\_\_\_\_

Do you use controlled substances?  Yes  No  N/A \_\_\_\_\_

Women: Are you  Pregnant/Trying to get pregnant?  Nursing?  Taking oral contraceptives?

Are you allergic to any of the following? \_\_\_\_\_

- Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  Other \_\_\_\_\_

Do you have, or have you had, any of the following? \_\_\_\_\_

- AIDS/HIV Positive  Chest Pains  Frequent Headaches  Irregular Heartbeat  Scarlet Fever
- Alzheimer's Disease  Cold Sores/Fever Blisters  Genital Herpes  Kidney Problems  Shingles
- Anaphylaxis  Congenital Heart Disorder  Glaucoma  Leukemia  Sickle Cell Disease
- Anemia  Convulsions  Hay Fever  Liver Disease  Sinus Trouble
- Angina  Cortisone Medicine  Heart Attack/Failure  Low Blood Pressure  Spina Bifida
- Arthritis/Gout  Diabetes  Heart Murmur\*  Lung Disease  Stomach/Intestinal Disease
- Artificial Heart Valve\*  Drug Addiction  Heart Pace Maker\*  Mitral Valve Prolapse\*  Stroke
- Artificial Joint\*  Easily Winded  Heart Trouble/Disease  Pain in Jaw Joints  Swelling of Limbs
- Asthma  Emphysema  Hemophilia  Parathyroid Disease  Thyroid Disease
- Blood Disease  Epilepsy or Seizures  Hepatitis A  Psychiatric Care  Tonsillitis
- Blood Transfusion  Excessive Bleeding  Hepatitis B or C  Radiation Treatments  Tuberculosis
- Breathing Problem  Excessive Thirst  Herpes  Recent Weight Loss  Tumors or Growths
- Bruise Easily  Fainting Spells/Dizziness  High Blood Pressure  Renal Dialysis  Ulcers
- Cancer  Frequent Cough  Hives or Rash  Rheumatic Fever\*  Venereal Disease
- Chemotherapy  Frequent Diarrhea  Hypoglycemia  Rheumatism  Yellow Jaundice

Have you ever had any serious illness not listed above?  Yes  No  N/A \_\_\_\_\_

Comments: \_\_\_\_\_

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**CONSENT:**

- The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
- I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) \_\_\_\_\_. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
- Lastly, I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account.

Patient \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Parent or Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_