TIME DATE

PATIENT REGISTRATION

ID _____ Chart ID _____

First Name _____ Last Name _____ Middle Initial _____

Patient is (circle): Policy Holder Responsible Party Preferred Name _____

Responsible Party (if someone other than the patient)

First Name _____ Last Name _____ Middle Initial _____

Address:_____ City_____ State_____ Zip_____

Home phone: _____ Work phone: _____ Cell phone: _____

Birth Date:_____ Soc. Sec. #: _____ Drivers Lic: _____

(Circle One) -Responsible Party is also a Policy Holder for Patient -Primary Insurance Policy Holder -Secondary Insurance Policy Holder

Patient Information

Address:_____ City_____ State_____ Zip_____

Home phone: _____ Work phone: _____ Cell phone: _____

Sex (circle): Male Female Marital Status (circle): Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ Soc. Sec. #: _____ Drivers Lic: _____

Email: _____

How did you find out about our office? Please circle

Yellow Pages Our Website Our Sign Your insurance company Other_____

Referred by another patient, if so please indicate the patient's name. _____

*We greatly appreciate our patients referrals.

Section 2

Employment Status (circle): Full Time Part Time Retired

Student Status (circle): Full Time Part Time Pref. Pharmacy: _____

Medicaid ID: _____ Employer ID: _____ Carrier ID: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Patient (circle): Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

City, State, ZIP: _____ City, State, ZIP: _____

Remaining Benefits: _____ Remaining Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Patient (circle): Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

City, State, ZIP: _____ City, State, ZIP: _____

Remaining Benefits: _____ Remaining Deduct: _____

Time Date

Medical History

Patient Name: _____ Birth Date: _____

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? (circle) Yes No If yes, please explain _____
Have you ever been hospitalized or had a major operation? (circle) Yes No If yes, please explain _____
Have you ever had a serious head or neck injury? (circle) Yes No If yes, please explain _____
Are you taking medications, pills, or drugs? (circle) Yes No If yes, please explain _____
Do you take, or have you taken, Phen-Fen or Redux? (circle) Yes No _____
Are you on a special diet? (circle) Yes No _____
Do you use tobacco? (circle) Yes No
Do you use controlled substances? (circle) Yes No

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 (if yes, please explain) _____		

Do you have or have you had any of the following?

☐ AIDS/HIV	☐ 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	☐ 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 If so, please explain: _____

Comments: _____
_____
_____

To the best of my knowledge, the question 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 _____ Date _____