PATIENT REGISTRATION

First Name:________________________ Last Name:___________________________Middle Initial:_____

Preferred Name:___________________________

Patient Information

Address:____ Apt #:_______________________

City:___________________________________ State:___________ Zip Code:______________________

Cell Phone:______________________________ Home Phone:___________________________________

Date of Birth:________________________ Social Security Number:_______________________________

Sex: Male / Female Marital Status:____

Drivers License Number:___________________ Email:____

How did you hear about our office? ____

Primary Insurance Information

Name of Policy Holder:____

Policy Holder's SSN:__________________________ Policy Holder's Date of Birth:___________________

Employer:_________________________________	INS Company:_____________________________
Address:__________________________________	Member ID:_______________________________
Address 2:_______________________________	Group Number:____________________________
City, Sate, Zip:__________________________	

Secondary Insurance Information

Name of Policy Holder:____

Policy Holder's SSN:__________________________ Policy Holder's Date of Birth:___________________

Employer:_________________________________	INS Company:_____________________________
Address:__________________________________	Member ID:_______________________________
Address 2:_______________________________	Group Number:____________________________
City, Sate, Zip:__________________________	

CONFIDENTIAL HEALTH HISTORY

Patient Name:____ Date of Birth:___________________

1. **CIRCLE APPROPRIATE ANSWER** (Leave blank if you do not understand the question)

   Yes / No Are you under a physician's care now?
   Yes / No Have you ever been hospitalized or had a major operation?
   Yes / No Have you ever had a serious head or neck injury?
   Yes / No Do you take, or have you taken PhenFen or Redux? (If so circle which one)
   Yes / No Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
   Yes / No Are you on a special diet?
   Yes / No Do you use Tobacco?
   Yes / No Do you use controlled substances?
   Yes / No Are you taking any medications, pills, drugs?
   If so list them here:____

CHECK MARK IF YES OR LEAVE BLANK IF NO
WOMEN are you…

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

ALLERGIES

Aspirin___ Penicillin___ Codeine___ Acrylic___ Metal___ Latex___ Sulfa Drugs___

Local Anesthetics___ Other Allergies____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

Yes / No AIDS/HIV Positive	Yes / No Congenital Heart Disorder
Yes / No Alzheimer's Disease	Yes / No Convulsions
Yes / No Anaphylaxis	Yes / No Cortisone Medicine
Yes / No Anemia	Yes / No Diabetes
Yes / No Angina	Yes / No Drug Addiction
Yes / No Arthritis/Gout	Yes / No Easily Winded
Yes / No Artificial Heart Valve	Yes / No Emphysema
Yes / No Artificial Joint	Yes / No Epilepsy or Seizures
Yes / No Asthma	Yes / No Excessive Bleeding
Yes / No Blood Disease	Yes / No Excessive Thirst
Yes / No Blood Transfusion	Yes / No Fainting Spells/Dizziness
Yes / No Breathing Problems	Yes / No Frequent Cough
Yes / No Bruise Easily	Yes / No Frequent Diarrhea
Yes / No Cancer	Yes / No Frequent Headaches
Yes / No Chemotherapy	Yes / No Genital Herpes
Yes / No Chest Pains	Yes / No Glaucoma

Yes / No Cold Sores/Fever Blisters	Yes / No Hay Fever
Yes / No Heart Attack/Failure	Yes / No Psychiatric Care
Yes / No Heart Murmur	Yes / No Radiation Treatments
Yes / No Heart Pacemaker	Yes / No Recent Weight Loss
Yes / No Heart Trouble/Disease	Yes / No Renal Dialysis
Yes / No Hemophilia	Yes / No Rheumatic Fever
Yes / No Hepatitis A	Yes / No Rheumatism
Yes / No Hepatitis B or C	Yes / No Scarlet Fever
Yes / No Herpes	Yes / No Shingles
Yes / No High Blood Pressure	Yes / No Sickle Cell Disease
Yes / No High Cholesterol	Yes / No Sinus Trouble
Yes / No Hives or Rash	Yes / No Spina Bifida
Yes / No Hypoglycemia	Yes / No Stomach/Intestinal Disease
Yes / No Irregular Heartbeat	Yes / No Stroke
Yes / No Kidney Problems	Yes / No Swelling of Limbs
Yes / No Leukemia	Yes / No Thyroid Disease
Yes / No Liver Disease	Yes / No Tonsillitis
Yes / No Low Blood Pressure	Yes / No Tuberculosis
Yes / No Lung Disease	Yes / No Tumors or Growths
Yes / No Mitral Valve Prolapse	Yes / No Ulcers
Yes / No Osteoporosis	Yes / No Venereal Disease
Yes / No Pain in Jaw Joints	Yes / No Yellow Jaundice
Yes / No Parathyroid Disease	

Have you ever had any serious illness not listed above? Yes / No

If so, what illnesses? ____

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient Signature:______________________________ Date:______________

Physician's Name:__________________________ Phone Number:______________

EMERGENCY CONTACT (In Case of Emergency)

Name:________________ Relationship:________ Phone Number:________________

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient(Parent or Guardian)	Date	Signature of Dentist	Date