REGISTRATION FORM

DATE: _____

LAST
NAME
_____

FIRST
NAME
_____

S.S #
_____

STREET
_____

CITY _____ STATE _____ ZIP _____

PHONE _____ BUSINESS _____ CELL _____

E-MAIL _____OCCUPATION_____

HOW WERE YOU REFERRED TO US_____

DATE OF BIRTH _____ MARITAL STATUS _____

MEDICAL DOCTORS
NAME
_____

TELEPHONE
_____

PERSON TO CONTACT IN CASE OF
EMERGENCY
_____

RELATIONSHIP _____ PHONE NUMBER _____

MEDICAL HISTORY

1. ARE YOU HAVING DISCOMFORT AT THIS TIME? _____

2. DO YOU FEEL VERY NERVOUS ABOUT HAVING DENTAL TREATMENT? _____

3. HAVE YOU EVER HAD A BAD EXPERIENCE IN A DENTAL OFFICE? _____

4. HAVE YOU EVER BEEN A PATIENT IN THE HOSPITAL DURING THE PAST TWO YEARS?
_____

5. HAVE YOU BEEN UNDER THE CARE OF A MEDICAL DOCTOR DURING THE PAST TWO YEARS?
_____

6. HAVE YOU TAKEN ANY MEDICINE OR DRUGS IN THE PAST TWO YEARS? _____

   IF YES, WHAT? _____

7. ARE YOU ALLERGIC TO PENICILLIN, ASPIRIN, CODEINE, OR ANY DRUG OR MEDICATION?
   IF SO, WHAT? _____

8. HAVE YOU EVER HAD ANY EXCESSIVE BLEEDING REQUIRING SPEACIAL TREATMENT OR BLOOD TRANSFUSION?

9. CIRCLE ANY OF THE FOLLOWING THAT YOU HAVE HAD OR HAVE AT PRESENT:

HEART FAILURE	EMPHYSEMA	AIDS
HEART DISEASE OR ATTACK	COUGH	HEPATITIS A
ANGINA PECTORIS	ASTHMA	LIVER DISEASE
HIGH BLOOD PRESSURE	TUBERCULOSIS	HEPATITIS B
HEART MURMUR	HAY FEVER	YELLOW JAUNICE
RHEUMATIC FEVER	DIABETES	HEMOPHILIA
CONGENITAL HEART LESIONS	ALLERGY OR HIVES	DRUG ADDICTIO
ARTIFICIAL HEART VALVE	CHEMOTHERAPY	VENEREAL DISEASE
HEART PACEMAKER	THYROID DISEASE	COLD SORES
ARTIFICIAL JOINT	ARTHRITIS	GENITAL HERPES
ANEMIA	RHEUMATISM	EPILEPSY
STROKE	GLAUCOMA	OR SEIZURES
KIDNEY TROUBLE	CORTISONE MEDICINE	FAINTING OR
PROBLEM WITH IMMUNE SYSTEM	BRUISE EASILY	DIZZY SPELL
ULCERS	NERVOUSNESS	SICKLE CELL
PAIN IN JAW JOINTS	EXCESSIVE URINATION	ANEMIA
EXCESSIVE THIRST	LOW BLOOD PRESSURE	CANCER
SINUS PROBLEMS	DIARRHEA	WEIGHT LOSS
		RADIATION
		TREATMENT

10. HAS YOUR DOCTOR EVER SAID YOU HAVE CANCER OR TUMOR? _____

11. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED? _____
    IF YES, PLEASE EXPLAIN _____

12. HAVE YOU EVER BEEN TOLD BY YOUR DOCTOR TO TAKE AN ANTIBIOTIC BEFORE DENTAL TREATMENT? _____

13. WOMEN: ARE YOU PREGNANT NOW? _____

14. ARE YOU WEARING REMOVABLE DENTAL APPLIANCES? _____

15. IS THERE ANYTHING ELSE ABOUT YOUR HEALTH THAT SHOULD BE BROUGHT TO OUR ATTENTION? _____

DATE_____SIGNATURE OF PATIENT/ GUARDIAN X_____

DATE _____ SIGNATURE OF DENTIST _____

INSURANCE INFORMATION

INSURANCE COMPANY
NAME_____

GROUP NUMBER _____

EMPLOYER
NAME _____

SECONDARY INSURANCE COMPANY
NAME _____

GROUP NUMBER _____

TO THE BEST OF MY KNOWLEDGE, ALL THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF I HAVE ANY CHANGES IN MY HEALTH, OR IF MY MEDICINES CHANGE, I WILL INFORM THE DENTIST AT THE NEXT APPOINTMENT. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THE POLICY OR PLAN.

I HAVE RECEIVED A COPY OF THE ACKNOWLEDGMENT NOTICE OF PRIVACY PRACTICE.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN X_____