REGISTRATION / HISTORY FORM

PATIENT INFORMATION

PATIENT _____ Home _____ Work _____ CELL _____
Last Name First Name MI

Address _____ City _____ Zip _____ E-Mail _____

Birth Date ___/___/___ Social Security No. _____ ( ) Male ( ) Female ( ) Single ( ) Married

Employer _____ Spouse's Name _____ Spouse's Empl. _____

PERSON RESPONSIBLE FOR ACCOUNT ( ) Patient _____

Address _____

Employer _____ Social Security No. _____

Referred to this office by _____

Previous Dentist Name/Phone # _____

Are you under a physician's care now?	O Yes	O No	O N/A	_____
Have you ever been hospitalized or had a major operation?	O Yes	O No	O N/A	_____
Have you ever had a serious head or neck injury?	O Yes	O No	O N/A	_____
Are you taking any medications, pills, or drugs? List	O Yes	O No	O N/A	_____
Do you take, or have you taken, Phen-Fen or Redux?	O Yes	O No	O N/A	_____
Have you taken Fosamax, Boniva, Actonel or any other medications containing bisposphonates?	O Yes	O No	O N/A	_____
Are you on a special diet?	O Yes	O No	O N/A	_____
Do you use tobacco?	O Yes	O No	O N/A	_____
Do you use controlled substances?	O Yes	O No	O N/A	_____
Is Pre-Medication necessary prior to Dental Work?	O Yes	O No	O 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	☐ Chemotherapy	☐ Frequent Headaches	☐ Kidney Problems	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Chest Pains	☐ Glaucoma	☐ Leukemia	☐ Shingles
☐ Anaphylaxis	☐ Cold Sores/Fever Blisters	☐ Hay Fever	☐ Liver Disease	☐ Sickle Cell Disease
☐ Anemia	☐ Congenital Heart Disorder	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Sinus Trouble
☐ Angina	☐ Convulsions	☐ Heart Murmur*	☐ Lung Disease	☐ Spina Bifida
☐ Arthritis/Gout	☐ Cortisone Medicine	☐ Heart Pace Maker*	☐ Mitral Valve Prolapse*	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve*	☐ Diabetes	☐ Heart Trouble/	☐ Pain in Jaw Joints	☐ Stroke
☐ Artificial Joint*	☐ Drug Addiction	☐ Hemophilia	☐ Parathyroid Disease	☐ Swelling of Limbs
☐ Asthma	☐ Easily Winded	☐ Hepatitis A	☐ Parkinson Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Emphysema	☐ Hepatitis B or C	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Thinner	☐ Epilepsy or Seizures	☐ Herpes	☐ Radiation Treatments	☐ Tuberculosis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ High Blood Pressure	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Breathing Problem	☐ Excessive Thirst	☐ Hives or Rash	☐ Renal Dialysis	☐ Ulcers
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ Hypoglycemia	☐ Rheumatic Fever*	☐ Yellow Jaundice
☐ Cancer	☐ Frequent Cough	☐ Irregular Heartbeat	☐ Rheumatism	

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

Comments: _____

DENTAL INSURANCE

Company _____
Address _____
Phone # _____
Subscriber's
Name _____
SS # _____ Birth Date _____
ID or Group # _____
Subscriber's Employer _____

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I hereby certify that the above information is true and correct.

Signed: _____ Date: _____
Patient / Parent / Guardian (If under 18)