PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT'S NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
HOME PHONE NO.: _____ BUSINESS PHONE NO.: _____
BIRTHDATE: _____ AGE: _____ MALE: _____ FEMALE: _____
MARITAL STATUS: _____ HEIGHT: _____ WEIGHT: _____
PATIENT'S EMPLOYER-OCCUPATION: _____
PATIENT'S SOCIAL SECURITY NO.: _____
NAME OF INSURANCE COMPANY: _____
INSURANCE PHONE NO.: _____
INSURANCE POLICY HOLDER _____ EMPLOYER _____
POLICY HOLDER SSN: _____ BIRTHDATE: _____

Have you or any member of your family been a patient at this office? Yes No Who? _____

1. Are you having pain or discomfort at this time? ..... Yes No
2. Have you ever been a patient in a hospital? ..... Yes No
3. Have you ever had any major surgery? ..... Yes No
4. Have you been under the care of a medical doctor the past 2 years? ..... Yes No
   Physician name: _____ Phone No. (____) _____
5. Are you now taking any medication, drugs, or pills? ..... Yes No
   If yes, please list _____
6. Are you allergic to or have ever reacted adversely to any medication or substance? ..... Yes No
   If yes, please list _____
7. Please circle Yes or No by each item if you have or ever have had any of the following:

Heart failure	Yes	No	Artificial joints(hip, knee, etc.)	Yes	No	Venereal disease	Yes	No
Heart disease or attack	Yes	No	Kidney trouble	Yes	No	HIV Positive/AIDS	Yes	No
Angina or chest pain	Yes	No	Ulcers	Yes	No	Cold sores/Fever blisters	Yes	No
Congenital heart disease	Yes	No	Diabetes	Yes	No	Blood transfusion	Yes	No
Heart murmur	Yes	No	Thyroid problems	Yes	No	Hemophilia	Yes	No
High blood pressure	Yes	No	Glaucoma	Yes	No	Anemia	Yes	No
Arteriosclerosis	Yes	No	Cosmetic surgery	Yes	No	Sickle cell disease	Yes	No
Mitral valve prolapse	Yes	No	Emphysema	Yes	No	Bruise easily	Yes	No
Artificial heart valve	Yes	No	Chronic cough	Yes	No	Liver disease	Yes	No
Heart pacemaker	Yes	No	Tuberculosis	Yes	No	Yellow jaundice	Yes	No
Heart surgery	Yes	No	Asthma	Yes	No	Severe headache/injury	Yes	No
Rheumatic fever	Yes	No	Allergies or hives	Yes	No	Epilepsy or seizures	Yes	No
Arthritis or rheumatism	Yes	No	Sinus trouble / Hay fever	Yes	No	Fainting or dizzy spells	Yes	No
Blood thinners	Yes	No	Radiation therapy	Yes	No	Nervousness	Yes	No
Cortizone medicine	Yes	No	Chemotherapy	Yes	No	Psychiatric treatment	Yes	No
Drug addiction	Yes	No	Hepatitis A(infectious)	Yes	No	Developmentally disabled	Yes	No
Stroke	Yes	No	Abnormal bleeding	Yes	No	Difficulty w/ dental work	Yes	No
Cancer or tumor	Yes	No	Hepatitis B or C	Yes	No	Any other disease/condition	Yes	No

Please explain more if you circled yes to any item or if you have any remarks: _____

_____

Name of a person to notify in an emergency _____ Phone (____) _____

FOR WOMEN ONLY. Are you pregnant? Yes No What month _____ Are you nursing? Yes No
Are you taking birth control? Yes No

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.

SIGNATURE _____ DATE _____

(If patient is under 18, parent or guardian must sign)