PATIENT REGISTRATION FORM

PATIENT INFORMATION

Today's Date:_____

Patients Name_____ Preferred: _____
Last First M.

Date of Birth:_____ Age:_____ Single □ Married □ Divorced □ Minor □ Widowed □

Male □ Female □

Telephone Number:_____ Cell Phone:_____

Mailing Address:_____ Street Address:_____

City:_____ State:_____ Zip:_____

Driver's License No:_____ Social Security No of patient:_____

Contact Person not living with you:_____ Relationship:_____

Address of above:_____ Phone No_____

Has anyone in your family been a patient here before? □ yes □ no If yes, who?_____

GUARANTOR INFORMATION

Who is responsible for this account?_____ Relationship_____

Address if different from patient:_____

Phone_____ Social Security No of responsible party:_____

Drivers License of Guarantor:_____ Guarantor DOB: _____

Guarantors Employer:_____ Occupation:_____

Business Address:_____ Bus. Phone:_____

If Married: Spouse's Name_____

Spouse's Employer:_____ Spouse's work number:_____

Employer Address:_____

Name of General Dentist:_____ **Physician:**_____

Who referred you to our office?_____

Reason for being here: _____

_____

_____

PATIENT MEDICAL HISTORY

PATIENT NAME: AGE:

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N)

Have you had any medical care or been in the hospital during the last five years? Describe:_____ Y N

_____

Are you taking ANY medications (prescribed, over-the-counter, herbs, ANYTHING)? If yes, List: Y N

_____

_____

Do you have any allergies or are you sensitive to any foods, drugs or medications (for instance eggs, Penicillin, Codeine, etc) If yes, what medication and reaction does it cause? Y N

_____

Have you ever taken bone loss prevention drugs such as Fosamax, Boniva, Reclast injections or other similar drugs? Y N

Do you bleed easily following a wound, cut or surgery? Y N

Do you take blood thinners such as aspirin, Coumadin or Plavix? Y N

Have you ever had breathing difficulty such as asthma, chronic cough, emphysema or lung disorders? Y N

Do you smoke? If yes, how many packs per day?_____ Y N

Have you had any of the following?:

- ☐ Stroke
- ☐ TIA=Transient Ischemic Attack
- ☐ Heart Disease
- ☐ Rheumatic Fever
- ☐ Arthritis/Rheumatism
- ☐ Heart Murmur/MVP
- ☐ Chest Pain
- ☐ High/Low Blood Pressure
- ☐ Anemia
- ☐ Hepatitis
- ☐ Kidney Disease/Trouble
- ☐ Liver Disease/Yellow Jaundice
- ☐ Diabetes
- ☐ Ulcers
- ☐ Glaucoma
- ☐ Tuberculosis
- ☐ AIDS/HIV
- ☐ Cold Sores/Fever Blisters
- ☐ Blood Transfusions
- ☐ Hemophilia
- ☐ Sickle Cell Disease
- ☐ Nose Obstruction/Sinus Trouble
- ☐ TMJ/Jaw Joint Disorders
- ☐ Nervous/Mental Disorder
- ☐ Latex Sensitivity

Do you have any artificial or replacement heart valves or a joint prosthesis replacement? Y N

Have you or anyone in your family ever experienced an unfavorable reaction or result from a previous medical or dental treatment or anesthetic? Y N

Have you taken any Steroids (ACTH, Cortisone, Prednisone etc) during the last year? Y N

(Female) Are you pregnant or do you think you could be pregnant? Yes_____months Y N

Have you ever or do you presently use recreational/illicit drugs? (Important concerning anesthesia) Y N

Have you sought professional care for drug abuse, alcoholism or emotional disorders? Y N

Do you have any other disease, condition or problem not listed here? If yes, please specify: Y N

_____

I understand the importance of providing a truthful health history to assist in providing the best care possible. The information that I have provided here is complete and accurate.

_____ _____

Patient/Guardian Signature Date