PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ (PLEASE PRINT) Home Phone (____) _____

Patient _____
Last Name First Name Middle Initial Preferred Name

Street Address _____ City _____ State _____ Zip _____

E-mail _____ Cell Phone (____) _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for ____ years

Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

Spouse/Parent Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Who is responsible for this account? _____ Relationship to Patient _____

Social Security # _____ Spouse/Parent's Social Security # _____

Name of Dental Insurance Company _____ Group Number _____

In case of emergency, who should be notified? _____ Phone (____) _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____

Have you ever had any of the following? (check boxes that apply):

☐ Allergies
☐ Arthritis
☐ Artificial Heart Valves or Joints, Screws, etc
☐ Back Problems
☐ Bleeding Abnormally
☐ Blood Disease
☐ Cancer
☐ Chemical Dependency
☐ Chronic Diarrhea
☐ Circulatory Problems
☐ Congenital Heart Lesions
☐ Diabetes
☐ Epilepsy
☐ Headaches
☐ Heart Murmur
☐ Heart Problems
☐ Hemophilia
☐ Hepatitis, Jaundice or Liver Disease
☐ Hernia Repair
☐ High Blood Pressure
☐ HIV/AIDS
☐ Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Nervous Problems
☐ Pacemaker
☐ Psychiatric Care
☐ Radiation Treatment
☐ Recent Weight Loss
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Sinus Problems
☐ Special Diet
☐ Stroke
☐ Swollen Neck Glands
☐ Ulcer
☐ Venereal Disease

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia? ☐ Yes ☐ No

If so, what? _____

Have you ever responded adversely to medical or dental treatment? ☐ Yes ☐ No

Are you taking any medication at this time? _____ If so, what? _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) ☐ Yes ☐ No

Are you under the care of a physician? ☐ Yes ☐ No For what conditions? _____

If patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Due date _____

Are you nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Is there anything else we should know about your medical history? _____

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