Date ______________________

PATIENT REGISTRATION

ID: ____________ Chart ID: ____________

First Name: ____________________ Last Name: ____________________ Middle Initial: ____

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: ____________________

Responsible Party (if someone other than the patient)

First Name: ____________________ Last Name: ____________________ Middle Initial: ____

Address: ____________________ Address 2: ____________________

City, State, Zip: ____________________ Pager: ____________

Home Phone: ____________ Work Phone: ____________ Ext: ______ Cellular: ____________

Birth Date: ____________ Soc Sec: ____________ Drivers Lic: ____________

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: ____________________ Address 2: ____________________

City: ____________ State / Zip: ______ ____________ Pager: ____________

Home Phone: ____________ Work Phone: ____________ Ext: ______ Cellular: ____________

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: ____________ Age: ______ Soc. Sec: ____________ Drivers Lic: ____________

E-mail: ____________________ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: ____________ Pref. Dentist: ____________

Employer ID: ____________ Pref. Pharmacy: ____________

Carrier ID: ____________ Pref. Hyg.: ____________

Section 3

Spouse's Name: ____________

Spouse's Work #: ____________

Who Referred You?: ____________

Credit Card Exp: ____________

Credit Card #: ____________

Primary Insurance information

Name of Insured: ____________________ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. See: ____________ Insured Birth Date: ____________

Employer: ____________________ Ins. Company: ____________________

Address: ____________________ Address: ____________________

Address 2: ____________________ Address 2: ____________________

City,State,Zip: ____________________ City,State,Zip: ____________________

Rem. Benefits: ________.00 Rem. Deduct: ________.00

Secondary Insurance Information

Name of Insured: ____________________ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ____________ Insured Birth Date: ____________

Employer: ____________________ Ins. Company: ____________________

Address: ____________________ Address: ____________________

Address 2: ____________________ Address 2: ____________________

City,State,Zip: ____________________ City,State,Zip: ____________________

Rem. Benefits: ________.00 Rem. Deduct: ________.00

MEDICAL HISTORY

PATIENT NAME ______________________________ Birth Date ______________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

	Yes	No	
Are you under a physician's care now?	◯	◯	If yes, please explain: ______________
Have you ever been hospitalized or had a major operation?	◯	◯	If yes, please explain: ______________
Have you ever had a serious head or neck injury?	◯	◯	If yes, please explain: ______________
Are you taking any medications, pills, or drugs?	◯	◯	If yes, please explain: ______________
Do you take, or have you taken, Phen-Fen or Redux?	◯	◯	______________
Are you on a special diet?	◯	◯	______________
Do you use tobacco?	◯	◯	
Do you use controlled substances?	◯	◯	

Women: Are you:

Pregnant / Trying to get pregnant? ◯ Yes ◯ No   Taking oral contraceptives? ◯ Yes ◯ No   Nursing? ◯ Yes ◯ No

Are you allergic to any of the following (check if yes)?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: ______________________________

Do you have, or have you had, any of the following? **Please check if Yes**

◯ AIDS/HIV Positive
◯ Alzheimer's Disease
◯ Anaphylaxis
◯ Anemia
◯ Angina
◯ Arthritis/Gout
◯ Artificial Heart Valve
◯ Artificial Joint
◯ Asthma
◯ Blood Disease
◯ Blood Transfusion
◯ Breathing Problem
◯ Bruise Easily
◯ Cancer
◯ Chemotherapy
◯ Chest Pains
◯ Cold Sores/Fever Blisters
◯ Congenital Heart Disorder
◯ Convulsions

◯ Cortisone Medicine
◯ Diabetes
◯ Drug Addiction
◯ Easily Winded
◯ Emphysema
◯ Epilepsy or Seizures
◯ Excessive Bleeding
◯ Excessive Thirst
◯ Fainting Spells/Dizziness
◯ Frequent Cough
◯ Frequent Diarrhea
◯ Frequent Headaches
◯ Genital Herpes
◯ Glaucoma
◯ Hay Fever
◯ Heart Attack/Failure
◯ Heart Murmur
◯ Heart Pace Maker
◯ Heart Trouble/Disease

◯ Hemophilia
◯ Hepatitis A
◯ Hepatitis B or C
◯ Herpes
◯ High Blood Pressure
◯ Hives or Rash
◯ Hypoglycemia
◯ Irregular Heartbeat
◯ Kidney Problems
◯ Leukemia
◯ Liver Disease
◯ Low Blood Pressure
◯ Lung Disease
◯ Mitral Valve Prolapse
◯ Pain in Jaw Joints
◯ Parathyroid Disease
◯ Psychiatric Care
◯ Radiation Treatments
◯ Recent Weight Loss

◯ Renal Dialysis
◯ Rheumatic Fever
◯ Rheumatism
◯ Scarlet Fever
◯ Shingles
◯ Sickle Cell Disease
◯ Sinus Trouble
◯ Spina Bifida
◯ Stomach/intestinal Disease
◯ Stroke
◯ Swelling of Limbs
◯ Thyroid Disease
◯ Tonsillitis
◯ Tuberculosis
◯ Tumors or Growths
◯ Ulcers
◯ Venereal Disease
◯ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain:

____

Comments:

____

____

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________ DATE ____________