Patient Registration Information

Name ________________________________ Spouse/Parent ________________________

Date of Birth______/______/____________ Your Home Phone ___________________

Social Security # ______-_____-______ Your Cell Phone ________-_____________

Address:________________________________ Work Phone _______-_________________

City:_________________ Zip:_____________ Email address ________________________

Sex: _______________ Preferred method of communication:
(please circle) Call or Text

Employer (or Parent's):____________________ Occupation:___________________________

Purpose of this appointment: ____

Are you pleased with your past dental care? ____

Who referred you to our office? ____

Family Physician: _________________________ Hospital/Location: _____________________

Please select method of payment:

_____ Payment as treatment is received.

_____ Dental Insurance. Name of Company: Primary __________________________________
Secondary_________________________________

Name of Policyholder ____________________________________
Employer ____________________________________
Date of Birth ____________________________________
Address ____________________________________
City, State, Zip Code ____________________________________
Phone Number ____________________________________

_____Title XIX. Title XIX number: ______________________ County: __________________

_____ Other: ____

Health conditions you may have, or medications that you are taking, can have an important relationship with the dental care you receive. As your dental team, we are legally obligated to ask the following questions on the back of this form. Thank you for answering them.

MEDICAL HISTORY

Have you been a patient in the hospital within the last 2 years?.. Yes No
Have you ever had any excessive bleeding requiring treatment?.. Yes No
Have you ever been denied when attempting to donate blood?... Yes No

Medical Conditions - *Please check all past and present that apply*

- ☐ Acid reflux/GERD
- ☐ AIDS
- ☐ Angina (Chest Pain)
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Blood Thinners
- ☐ Blood Transfusion
- ☐ Cancer or Leukemia
- ☐ Chemotherapy
- ☐ Cold Sores
- ☐ COPD or Emphysema
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Drug Addiction
- ☐ Glaucoma
- ☐ Gonorrhea
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ High/Low Blood Pressure
- ☐ HIV Positive
- ☐ Liver Disease
- ☐ Kidney Trouble
- ☐ Osteoporosis/Bisphosphonates
- ☐ Pacemaker
- ☐ Psychiatric Treatment
- ☐ Radiation
- ☐ Rheumatic Fever
- ☐ Seizures or Epilepsy
- ☐ Sinus Trouble
- ☐ Steroids (Prednisone, Cortisone)
- ☐ Stroke
- ☐ Syphilis
- ☐ Thyroid Problems
- ☐ Tobacco/Vaping
- ☐ Tuberculosis
- ☐ Ulcers

Allergies or Adverse Reactions – *Please check all that apply*

- ☐ Local anesthetics
- ☐ Amoxicillin or Penicillin
- ☐ Aspirin
- ☐ Ibuprofen
- ☐ Hydrocodone
- ☐ Cephalexin/Keflex
- ☐ Metals
- ☐ Sulfa Drugs
- ☐ Latex
- ☐ Hay Fever/Seasonal
- ☐ Other_________________

Medications: Are you currently taking any prescribed or over-the-counter medications?............ Yes No
If yes, please list or provide on separate page:____
____

When you walk upstairs or take a walk, do you ever have to stop because
of pain in your chest, shortness of breath, or because you are tired?..................................... Yes No
Do you ever wake up from sleep gasping or short of breath?.. Yes No
Are you currently under medical care?.. Yes No
If yes, please explain:____

If you have any disease or problem not listed, please explain:
____
Women: Are you currently pregnant or breast feeding?... Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medications change, I will inform the dentist at the next appointment without fail. I have received, read and understand your Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand that this office has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time at the address above to obtain a current copy of the Notice of Private Practices.

Signed:____ Date:_________________________

Today's Date						
Patient's Initials						
Blood Pressure						