PATIENT REGISTRATION AND MEDICAL HISTORY

Date_____ Home Phone(___)_____
Patient Name_____Cell Phone(___)_____
StreetAddress_____
City_____State_____Zip_____
Email_____
Date of Birth_____ Sex M or F Social Security#_____
Employer_____ Address_____
Occupation_____ Business Phone_____

Spouse/Parent Name_____ Spouse/Parent Birthday_____
Spouse/Parent Employer_____ Business Phone_____

Person responsible for this account_____
Social Security #_____ Spouse/Parent Social Security #_____

Name of dental insurance company_____ Group #_____
In case of emergency, who should be notified? _____
Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name_____ Phone(___)_____
Are you under a physician's care now? ___ If so, reason for treatment_____
Are you taking any medication at this time? _____
_____

Pease circle any illnesses you have ever had:

Allergies	Tuberculosis	Anemia	Kidney or Liver
Rheumatic fever	Diabetes	Heart Trouble	Asthma
Infectious hepatitis	Epilepsy	Glaucoma	HIV Infection
Joint Replacement			

Other(please explain)_____

Have you ever had any unusual reaction to an anesthetic or drug (penicillin)?_____
_____
Is there any other information that should be known about your health? _____
About previous dental visits? _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in completion of this form.

Date Signature