

(PLEASE PRINT)

# PATIENT REGISTRATION AND MEDICAL HISTORY

DATE \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Patient \_\_\_\_\_

Last name First Name Initial Preferred Name

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Spouse Name \_\_\_\_\_

Spouse Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Social Security # \_\_\_\_\_ Spouse's Social Security # \_\_\_\_\_

Name of Dental Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_

Name of second Dental Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_

In case of emergency, who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of Last Physical \_\_\_\_\_

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

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Heart Problems          | <input type="checkbox"/> Epilepsy                             | <input type="checkbox"/> Special Diet        |
| <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Headaches                            | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Low Blood Pressure      | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease | <input type="checkbox"/> Rheumatic Fever     |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Cancer                               | <input type="checkbox"/> Sinus Problems      |
| <input type="checkbox"/> Nervous Problems        | <input type="checkbox"/> Psychiatric Care                     | <input type="checkbox"/> A.I.D.S." or Other  |
| <input type="checkbox"/> Radiation Treatment     | <input type="checkbox"/> TMJ                                  | Immunosuppressive Disorders                  |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Allergies to Anesthetics             | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Allergies to Medicine or Drugs       | <input type="checkbox"/> Ulcer               |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> General Allergies                    | <input type="checkbox"/> Venereal Disease    |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Blood Disease                        | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> Respiratory Disease     | <input type="checkbox"/> Arthritis                            | <input type="checkbox"/> Hemophilia          |

Do you have any drug allergies or have you ever had an adverse reaction to any medication? \_\_\_\_\_ If so, what? \_\_\_\_\_

Have you ever responded adversely to medical or dental treatment? \_\_\_\_\_

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

Are you under the care of a physician?  Yes  No

For what conditions? \_\_\_\_\_

(Women) Do you suspect that you are pregnant?  Yes  No

Have you had bisphosphonate therapy  Yes  No -  Check box if you have taken AREDIA or ZOMETA

For How Long? \_\_\_\_\_  Have you had IV therapy for multiple Myeloma or Metastatic Cancer or Pagets Disease or Osteoporosis

Have you taken oral bisphosphonate? \_\_\_\_\_ Which kind:  Actonel  Boniva  Fosamax  Shelif  Didronel

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

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 benefit 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 the completion of this form. I understand that I am responsible for any court costs, unpaid bills, collection agency costs and attorney fees.

Date \_\_\_\_\_ Signature \_\_\_\_\_