PATIENT REGISTRATION AND MEDICAL HISTORY

Date_____ (Please Print) Home Phone (____)_____
Patient_____
(LAST) (FIRST) (INITIAL)
(PREFERRED NAME)
Street Address_____City_____State_____Zip_____
E-Mail Address_____
Sex: __M __F Age_____ Birthdate _____/_____/_____ _Single _Married _Widowed _Divorced _Child
Employed by _____Occupation_____
Business Address_____ Business 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_____ 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 those that apply):

__Heart Problems	__Epilepsy	__Special Diet
__High Blood Pressure	__Headaches	__Swollen Neck Glands
__Low Blood Pressure	__Hepatitis, Jaundice or Liver Disease	__Rheumatic Fever
__Circulatory Problems	__Cancer	__Sinus Problems
__Nervous Problems	__Psychiatric Care	__HIV/AIDS or Other ImmunosuppresiveDisorders
__Radiation Treatment	__Chronic Diarrhea	
__Artificial Heart Valves or Joints	__Allergies to Anesthetics	__Stroke
__Recent Weight Loss	__Allergies to Medicine or Drugs	__Ulcer
__Back Problems	__General Allergies	__Venereal Disease
__Diabetes	__Blood Disease	__Chemical Dependency
__Respiratory	__Arthritis	__Hemophilia
__Asthma		

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
_____
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? _____
(Woman) Do you suspect that you are pregnant? ___Yes ____No Are you nursing? __Yes __No

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 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 the completion of this form.

Date_____ Signature_____