PATIENT REGISTRATION AND MEDICAL HISTORY (Please Print)

Date _____ Home Phone _____ Cell # _____ email: _____

Patient _____ Emergency # other than home _____

Street Address _____ City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

Employed by _____ Occupation _____

Business Address _____ Business Phone _____ Ext # _____

Who is responsible for the account? _____ Relationship to patient _____

Social Security # _____ Insured Social Security # _____ Insured Date of Birth _____

Name of Dental Insurance Company _____ Group# _____

Whom may we thank for referring you? _____ _____

MEDICAL HISTORY : your M.D.'s name _____ and Phone# _____

Do you, or have you had any of the following? (**Please Circle**)

Heart Problems	Headaches	Chronic Cough
High Blood Pressure	Hepatitis, Jaundice or Liver Disease	Night sweats
Low Blood Pressure	Cancer	Cold Sores
Circulatory Problems	Psychiatric Care	Mouth Ulcers
Nervous Problems	Chronic Diarrhea	been Hypnotized
Radiation Treatment	Allergies to Foods or Drugs	Smoker
Artificial Heart Valves or Joints	Blood Disease	Hyperthyroidism
Recent Weight Loss	Arthritis	Hypothyroidism
Diabetes	Swollen Glands	High Cholesterol
Respiratory Disease	Rheumatic Fever	Hearing Aids / loss
Epilepsy	Sinus Problems	
"A.I.D.S."	Stroke	
HIV positive	Venereal Disease	

Are you taking any medications? (Please list below)

Are you under the care of a physician? ☐ Yes ☐ No
For what conditions? _____

(Women)Is there a possibility you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Are you allergic to any medications? Any foods?(Please List) _____

Have you ever been hospitalized & for what conditions? _____ When? _____

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

Date _____ Patient Signature/If minor parent _____