# PATIENT REGISTRATION INFORMATION

**Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.**

*Patient name:* _____ *How do you prefer to be addressed?*_____

*Date of birth:* _____ *Sex:* _____ *Age:* _____ *Referred to us by:* _____

*Home address:* _____ *City:* _____ *State:* _____ *Zip:* _____

*Billing address (if different):* _____ *City:* _____ *State:* _____ *Zip:* _____

*Home phone:* _____ *Cell:* _____ *E-mail:* _____ *Driver's license #:* _____ *State:* ____

*SS #:* _____ *Employer/Occupation:* _____ *Bus. Phone:* _____

*Spouse's name & contact # :*_____

*Emergency contact & phone# (other than spouse)*_____

*Primary dental insurance:* _____ *Group#:*_____

*Subscribers name:* _____ *Subscribers birth date*_____ *SS#*_____

*Secondary dental insurance:* _____ *Group#:*_____

*Subscribers name:* _____ *Subscribers birth date*_____ *SS#*_____

*Name of your medical doctor:* _____ *Date of last visit to medical doctor:* _____

*Name of previous dentist:*_____ *Date of last visit to dentist:*_____

# MEDICAL HEALTH HISTORY

***Do you have or have you ever had***

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Heart Trouble | Y/N | Swelling of Feet/ Ankles, Hands | Y/N | Tuberculosis | Y/N | Pain in Jaw Joints | Y/N |
| Heart Surgery | Y/N | Fainting or Dizziness | Y/N | Frequent Cough | Y/N | Glaucoma | Y/N |
| Artificial Heart Valve | Y/N | Stroke | Y/N | Liver Disease | Y/N | Epilepsy/Seizures | Y/N |
| Heart Pacemaker / Stent | Y/N | Diabetes Type 1 or 2 | Y/N | Hepatitis A, B, C | Y/N | Psychiatric Care | Y/N |
| Heart Murmur/ Mitral Valve Prolapse | Y/N | Yellow Jaundice | Y/N | Nervousness | Y/N | Drug/Alcohol Addiction | Y/N |
| Rheumatic Fever | Y/N | Hypoglycemia | Y/N | Alzheimer's Disease | Y/N | Blood Transfusion | Y/N |
| High Blood Pressure | Y/N | Excessive Thirst | Y/N | AIDS/HIV | Y/N | Hemophilia (bleeder) | Y/N |
| Low Blood Pressure | Y/N | Artificial Joints/Hips | Y/N | Recent Weight Loss | Y/N | Bleed Easily | Y/N |
| Blood Disease | Y/N | Kidney Trouble | Y/N | Cancer | Y/N | Herpes | Y/N |
| Anemia | Y/N | Ulcers | Y/N | Chemotherapy/ Radiation | Y/N | Venereal Disease | Y/N |
| Sickle Cell Anemia | Y/N | Asthma | Y/N | Thyroid Disorder | Y/N | Canker/Cold Sores | Y/N |
| Chest Pain | Y/N | Hay Fever | Y/N | Arthritis/Gout | Y/N | Sleep Apnea | Y/N |
| Shortness of Breath | Y/N | Lung Disease | Y/N | Rheumatism | Y/N | Frequent Headaches | Y/N |
| Blood Thinners | Y/N | Emphysema | Y/N | Cortisone Medication | Y/N | Dry Mouth/Eyes | Y/N |
| | | | | | | Shingles | Y/N |

## *Are you allergic to any of the following?*

| | | | | | |
|---|---|---|---|---|---|
| Local Anesthetics ("Novocaine") | Y/N | Penicillin or other Antibiotics | Y/N | Sulfa Drugs | Y/N |
| Barbiturates, sedative or sleeping pills | Y/N | Aspirin, Acetaminophen or Ibuprofen | Y/N | Codeine or narcotics | Y/N |
| Reactions to metals | Y/N | Latex or Rubber Dams | Y/N | Iodine | Y/N |

Please list any other allergies not listed _____

***Please complete other side***

| | | |
|---|---|---|
| Do you use tobacco Products? | Y/N | Type/Frequency_____ |
| Have you ever taken Fosamax or other bisphosphonate? | Y/N | _____ |
| Have you had any past or recent surgical procedures? | Y/N | _____ |
| Have you had any negative past dental experiences? | Y/N | _____ |
| Is there anything you would like to change with your smile? | Y/N | _____ |
| What can we do to make your appointment more pleasant? | | _____ |

***WOMEN:***

| | | |
|---|---|---|
| Are you taking contraceptives or other hormones? | Y/N | _____ |
| Are you Pregnant ? | Y/N | Expected Due Date_____ |
| Are you nursing? | Y/N | |
| Have you reached menopause? | Y/N | If so, any symptoms?_____ |

***MEN:***

| | | |
|---|---|---|
| Are you/have you taken medication for erectile dysfunction? | Y/N | _____ |

***Please list any medications and/or supplements you are currently taking. Please include dose and reason***

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

***Patient/Parent Signature*** ***Date***

_____ _____

***Dentist Signature*** ***Date***

*Medical History Updates:*