

# PATIENT REGISTRATION AND MEDICAL/DENTAL HISTORY

Medical Alert

Pharmacy Name \_\_\_\_\_ Phone \_\_\_\_\_

So that we may provide you with the best possible care, please complete both sides of this medical/dental history form.  
(PLEASE PRINT)

Date \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell/Pager \_\_\_\_\_ Email \_\_\_\_\_

Patient Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Social Security # \_\_\_\_\_ Driver's Lic.# \_\_\_\_\_

Sex:  Male  Female Age \_\_\_\_\_ Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Employed By \_\_\_\_\_

Occupation \_\_\_\_\_

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

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Tel. \_\_\_\_\_

Spouse Name \_\_\_\_\_ Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_

Employed By \_\_\_\_\_

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

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Tel. \_\_\_\_\_

Social Security # \_\_\_\_\_

Person Responsible For Account

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Hm# ( ) \_\_\_\_\_ DL# \_\_\_\_\_

Employer: \_\_\_\_\_

Wk# ( ) \_\_\_\_\_ Ext: \_\_\_\_\_ SS# \_\_\_\_\_

Dental Insurance Primary Carrier

Insured's Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Group Number \_\_\_\_\_ ID Number \_\_\_\_\_ Birthdate \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Dental Insurance Secondary Carrier

Insured's Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Group Number \_\_\_\_\_ ID Number \_\_\_\_\_ Birthdate \_\_\_\_\_

Insured's Employer \_\_\_\_\_

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

Whom may we thank for referring you? \_\_\_\_\_

## Medical History

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

Address \_\_\_\_\_ Tel. \_\_\_\_\_

Please check the box of any condition you may have had.

- |  |   |   |  |  |
|--|---|---|--|--|
| <input type="checkbox"/> A.I.D.S./ HIV Positive or Other | <input type="checkbox"/> Back Problems                  | <input type="checkbox"/> Epilepsy/Seizures                    | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Rheumatic Fever     |
| <input type="checkbox"/> Allergies to Anesthetics        | <input type="checkbox"/> Blood Disease                  | <input type="checkbox"/> General Allergies* (List Below)      | <input type="checkbox"/> Kidney Problem        | <input type="checkbox"/> Sinus Problems      |
| <input type="checkbox"/> Allergy to Colored Dyes         | <input type="checkbox"/> Blood Transfusion              | <input type="checkbox"/> Glaucoma                             | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Special Diet        |
| <input type="checkbox"/> Allergy to Latex                | <input type="checkbox"/> Cancer, Leukemia               | <input type="checkbox"/> Headaches                            | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Angina Pectoris                 | <input type="checkbox"/> Chemical Dependency            | <input type="checkbox"/> Heart Disease or Attack              | <input type="checkbox"/> Nervous Problems      | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Arthritis/Rheumatism            | <input type="checkbox"/> Chemotherapy/Radiation Therapy | <input type="checkbox"/> Heart Murmur                         | <input type="checkbox"/> Premedicate           | <input type="checkbox"/> Thyroid Disease     |
| <input type="checkbox"/> Artificial Heart Valves         | <input type="checkbox"/> Chronic Diarrhea               | <input type="checkbox"/> Heart Pacemaker                      | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Artificial Joints               | <input type="checkbox"/> Circulatory Problems           | <input type="checkbox"/> Hemophilia                           | <input type="checkbox"/> Recent Weight Loss    | <input type="checkbox"/> Ulcer               |
| <input type="checkbox"/> Aspirin Taken Daily             | <input type="checkbox"/> Contact Lenses                 | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease | <input type="checkbox"/> Respiratory Problem   | <input type="checkbox"/> Venereal Disease    |
| <input type="checkbox"/> Asthma                          | <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> High Blood Pressure                  |  | <input type="checkbox"/> Other* (List below) |

\*General Allergies: \_\_\_\_\_  
\*Other: \_\_\_\_\_

Patient Name

DENTAL HISTORY

What is the reason for your visit today?

Is there anything about having dental treatment that you would like us to know? Yes No

If yes, please describe

Date of Last: Dental Visit Dental Cleaning Full Mouth X-ray Bitewing X-rays

What treatment was done at your last dental visit?

Previous Dentist's Name Telephone

Address

City State Zip Code

How often do you have dental examinations? How often do you floss?

What other dental aids do you use? (Interplak, toothpick, etc.)

Do you have any dental problems now? Yes No If yes, please describe:

Circle "Yes" or "No" to each item.

Table with 3 columns: Do you:, Are any of your teeth sensitive to:, Have you ever experienced: with various dental-related questions and Yes/No options.

Do you have any drug allergies or have you ever had an adverse reaction to any medication or substance? Yes No

If yes, list

Have you ever responded adversely to medical or dental treatment? Yes No

Have you ever been advised to be pre-medicated prior to any dental treatment? Yes No

Are you taking any medication at this time? Yes No If yes, what

Have you ever taken Phen-Fen? Or Redux? Yes No If so, have you seen a cardiologist for a consult since taking it? Yes No

Are you under the care of a physician? Yes No If yes, for what condition

If Patient is a child what is his/her weight?

Have you had a recent transfusion? Yes No

Is there anything else we should know about your medical history

Women — Are you: Pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

I verbally reviewed the medical / dental information above with the parent / guardian & patient named herein. Staff /Dr.'s Initials Date

AUTHORIZATION AND RELEASE

The above information is accurate and complete to the best of my knowledge and is only for use in treatment, billing and processing of insurance for benefits for which I am entitled. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care, to third party payers and/or other health practitioners.

I authorize my insurance company to pay directly to the dental office the benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependents.

Signature of Patient or Parent of Minor

Date