PATIENT REGISTRATION AND MEDICAL HISTORY

Date_____ **(PLEASE PRINT)**

Patient_____ S.S. # ___-___-____
Last Name First Name Initial Nickname

Home Address_____City_____State_____Zip Code_____

Home # (___)_____Work # (___)_____Cell# or other_____Best # to reach you during business hours_____

Sex__Male__Female Drivers License #_____ Marital Status: Single – Married – Widowed Date of Birth_____
Please Circle Separated – Divorced - Minor

Occupation_____Employed by_____How Long Held_____

Business Address_____City_____State_____Zip Code_____

Spouse/Parent Name_____ S.S. #___-___-____Work# ( )_____Date of Birth_____

Spouses Occupation_____Employed by_____How Long Held_____

Business Address_____City_____State_____Zip Code_____

In case of an emergency, who should be notified?_____Phone # _____

Whom may we thank for referring you to our office?_____

DENTAL INSURANCE 1ST COVERAGE

Employee Name_____Employee Date Of Birth_____

Employer Name_____Address_____City_____Zip Code_____

Insurance Co.Name_____Address_____City_____Zip Code_____

Phone # (___)_____ Group or Policy #_____ S.S. # ___-___-____

DENTAL INSURANCE 2ND COVERAGE

Employee Name_____Employee Date Of Birth_____

Employer Name_____Address_____City_____Zip Code_____

Insurance Co.Name_____Address_____City_____Zip Code_____

Phone # (___)_____ Group or Policy #_____ S.S. # ___-___-____

HEALTH INSURANCE COVERAGE

Employee Name_____ Employee Date Of Birth_____

Employer Name_____Address_____City_____Zip Code_____

Insurance Co.Name_____Address_____City_____Zip Code_____

Phone # (___)_____ Group or Policy #_____ S.S. # ___-___-____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
I authorize release of any information concerning my (or my child's) health care advice and treatment to another dentist.
I hereby authorize payment of insurance benefits directly to the dentist otherwise payable to me.
I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. **I understand I am financially responsible for payments in full the day of service. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.**
I attest to the accuracy of the information on this page.

Patient's or Guardian's Signature_____Date_____ **(OVER)**

MEDICAL – DENTAL HISTORY FORM

Purpose for Initial Visit_____

How long since you last dental visit? _____

Have you ever responded adversely to medical or dental treatment?____NO ____YES, explain_____

Have you ever been told to pre-medicate prior to a dental appointment? ___NO ___YES, explain_____

Date of Last Physical Exam: _____ Physician Name_____ Phone #_____

Are you now or have you recently been under a physician's care? _____NO _____YES, explain:_____

Check any of the following that you have had or suspected:

___Arthritis	___Rheumatic Fever	___Heart Trouble	___Heart Murmur	___High/Low Blood Pressure
___Chest Pain	___Stroke	___Shortness of Breath	___Asthma or Hay Fever	___Sinus Trouble
___Hepatitis or Jaundice	___Liver Disease	___Cancer or Tumor	___Tuberculosis	___Diabetes
___Anemia	___Lung Disease	___Venereal Disease	___Blood Disease	___Kidney/Bladder Trouble
___Prolonged Bleeding	___Fainting Tendency	___Epilepsy	___Thyroid Disease	___Glaucoma
___Radiation Treatment	___Psychiatric Care	___HIV or AIDS	___Blood Transfusion	___Circulatory Problems
___Nervous Problems	___Artificial Heart Valves	___Recent Weight Loss	___Back Problems	___Respiratory Problems
___Headaches	___Chronic Diarrhea	___General Allergies	___Special Diet	___Swollen Neck Glands
___Ulcer	___Chemical Dependency	___Hemophilia	___Pacemaker	___Prosthetic Joint Replacement

Check any of the following that you are taking or have taken:

___Cortisone Drugs ___Anticoagulants ___Tranquilizers ___Steroids ___Blood Thinners ___Sedatives

Are you taking any other medication?____NO____Yes, explain:_____

Are you taking any herbal supplements such as: **ginger, garlic, feverfew, ginseng or St. John's wort.?**
Please list_____

Are you allergic to or do you suffer ill effects from any of the following?

___Penicillin ___Dental Anesthesia ___Codeine
___Aspirin ___Household Bleach Any others, please list_____

WOMEN ONLY: Are you pregnant? ____NO ___YES, how many months?_____ Are you breast feeding?____NO ____YES

Are you presently taking any of the following? ___Birth Control Pills ___Shots ___Implants ___Hormone Therapy

CHILD ONLY:

DENTAL

Date of last visit to a dentist_____
For what service? _____
Has child complained about dental problems?____NO____YES
Explain_____
Any unhappy dental experiences? _____
Any injuries to mouth – teeth – head? ____NO ____YES
Explain_____
Any unusual speech habits? ____NO ____YES
Have missing teeth been replaced? ____NO ____YES
Orthodontic appliances ever worn? ____NO ____YES
Does your child brush teeth twice daily? ____NO ____YES
Do you assist child with brushing? ____NO ____YES
How often is dental floss used? _____
Child's attitude to dentistry_____

MEDICAL

Is child under care of a physician now? ____NO ____YES
Explain_____
Is child taking any medication or drugs? ____NO ____YES
Explain_____
Is there any excessive bleeding when cut? ____NO ____YES
Has child ever been hospitalized? ____NO ____YES
Explain_____
Is there any allergy to penicillin or other drugs ___NO ____YES
Explain_____
Are there other allergies: food – pollen – animals – dust - other?
Explain_____
Does child have good physical coordination? ____NO ____YES
Are there any emotional problems? ____NO ____YES
Explain_____

REPONSIBLE PARTY FOR PATIENT: _____ADDRESS_____
_____

The above information is true to the best of my knowledge.

SIGNATURE:_____**DATE**_____