

Patient Registration

How did you hear about our office? _____ Today's Date _____

Reason for your visit today? _____

Patient's Name _____ Sex M F Marital Status S M D O

Date of Birth _____ Age _____ SSN _____ Drivers License # _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone # _____ Work # _____ Cell/Other # _____

If we can correspond with you via email, your email address _____

Emergency Contact -
(Person NOT living with you) Name _____ Phone # _____

Insurance Company _____ Policy Holder _____ DOB _____ SSN _____

If secondary coverage, Insurance Company _____ Policy Holder _____

If Patient is a MINOR (under 18yrs old) please complete:

Person Responsible for account _____ D.O.B. _____ SSN _____
(Parent/Guardian)

Mailing Address (if different from above) _____

Medical History

Please **CIRCLE** all that apply to you:

AIDS	Depression	Hepatitis A	Pregnant (currently)
Allergies (seasonal)	Diabetes	Hepatitis B	Radiation (head/neck)
Anemia	Dizziness	Hepatitis C	Respiratory Problems
Arthritis	Drug Addiction	High Blood Pressure	Rheumatic Fever
Artificial Heart Valve	Emphysema	HIV Positive	Rheumatism
Artificial Joints	Excessive Bleeding	Jaundice	Scarlet Fever
Asthma	Fainting	Jaw Joint Pain	Seizures
Blood Disease	Glaucoma	Kidney Disease	Stomach Problems
Blood Thinners	Heart Conditions	Liver Disease	Stroke
Bruise Easily	Heart Lesion (congenital)	Low Blood Pressure	Thyroid Disease
Cancer	Heart Murmur	Mitral Valve Prolapse	Ulcers
Chemotherapy	Heart Surgery (last 6 mos)	Pacemaker	Veneral Disease
Other _____			

Have you ever had periodontal disease or treatment? _____

Do you have any of the following drug allergies?

Please **CIRCLE**

Aspirin Codeine
Darvon Erythromycin
Valium Nitrous Oxide
Percodan Penicillin
Sulfa Local Anesthetic
Latex Tetracycline
Other _____

Are you currently under physician's care? Y or N

Current Medications _____

Family Physician _____

Phone # _____

Date of last DENTAL visit _____

Previous Dentist _____

Patient/Guardian Signature _____