



Patient Registration

First Name Last Name Middle Initial

Patient Is: Policy Holder Responsible Party

Preferred Name

Responsible Party (if someone other than the patient)

First Name Last Name Middle Initial

Address

Home Phone

Work Phone

Mobile Phone

Birth Date

Social Security Number

Drivers License Number

Responsible Party is also a Policy Holder to Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address

Home Phone

Work Phone

Mobile Phone

Sex: Male Female

Marital Status: Married Single Divorced Separated Widowed

Birth Date

Social Security Number

Drivers License Number

Age

Email

I would like to receive correspondence via email

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Medicaid ID

Employer ID

Carrier ID

Preferred Dentist

Preferred Pharmacy

Referred Hygienist

Credit Card Number

Card Issuer

Exp Date

Security Code



Insurance Information

Primary Insurance Information

Name of Insured	Insured Soc. Sec. #	Insured Birth Date
Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		

Employer	Address	City/ST/Zip
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Insurance Company	Address	City/ST/Zip
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Reimbursement Benefits (\$)	Reimbursement Deductible (\$)
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Secondary Insurance Information

Name of Insured	Insured Soc. Sec. #	Insured Birth Date
Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		

Employer	Address	City/ST/Zip
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Insurance Company	Address	City/ST/Zip
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Reimbursement Benefits (\$)	Reimbursement Deductible (\$)
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Medical History

Patient Name _____

Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Are you on a special diet? Yes No _____
- Do you use tobacco? Yes No _____
- Do you use controlled substances? Yes No _____

Women: Are you...

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other

If Yes, please explain _____

Do you have any of the following?

- | | | | |
|--|--|--|---|
| AIDS/HIV Positive <input type="checkbox"/> Yes <input type="checkbox"/> No | Cortisone Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No | Renal Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alzheimer's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anaphylaxis <input type="checkbox"/> Yes <input type="checkbox"/> No | Drug Addiction <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis B or C <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Easily Winded <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Shingles <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Gout <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No | Hives or Rash <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypoglycemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joint <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Thirst <input type="checkbox"/> Yes <input type="checkbox"/> No | Irregular Heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No | Spina Bifida <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting Spells/Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach/Intestinal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Cough <input type="checkbox"/> Yes <input type="checkbox"/> No | Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling of Limbs <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breathing Problem <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bruise Easily <input type="checkbox"/> Yes <input type="checkbox"/> No | Genital Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain in Jaw Joints <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors or Growths <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pains <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack/Failure <input type="checkbox"/> Yes <input type="checkbox"/> No | Parathyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cold Sores/Fever Blisters <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Pace Maker <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No | Yellow Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Trouble/Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Have you ever had any serious illness not listed above? If Yes, please explain _____

Comments _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____

DATE _____