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PATIENT REGISTRATION

(please print legibly)

Date ______________________________

PERSONAL INFORMATION

Name ______________________________ SS# ______________
Address ______________________________
City ______________________ State ________ Zip________
Telephone: Home ______________________ Work ______________________
Cell ______________________ E-mail ______________________
Birth date __________ Sex ______ Marital Status __________ Spouse Name ______________
Occupation ______________________ Referred by ______________________

PERSON RESPONSIBLE FOR ACCOUNT

Name ______________________ Relationship ______________________
Birth date ______________________ SS# ______________________
Address ______________________________
City ______________________ State ________ Zip________
Telephone: Home ______________________ Work ______________________

DENTAL INSURANCE INFORMATION

Primary Insurance Co. ______________________________
Insurance Co. Address ______________________________
Employee ______________________ Relationship __________ SS# ______________
Employer ______________________ Policy #/Group # ______________________
Secondary Insurance Co. ______________________________
Insurance Co. Address ______________________________
Employee ______________________ Relationship __________ SS# ______________
Employer ______________________ Policy #/Group # ______________________

I understand that payment is my obligation regardless of insurance or any other third-party involvement.

SIGNATURE ______________________________ DATE ______________

MEDICAL HISTORY

(please print legibly)

Patient Name ______________________ Initial Date ____________

Updated ____________

Updated ____________

Updated ____________

Updated ____________

HEALTH INFORMATION

Personal Physician Name ______________________

Personal Physician Address ______________________

YES	NO	
☐	☐	1. Have you been hospitalized within the past 2 years? For what? ____________
☐	☐	2. Are you currently being treated by a physician? For what? ____________
☐	☐	3. Are you currently taking any medicines or drugs? What? ____________
☐	☐	4. Have you ever received counseling for excessive use of alcohol and/or prescription drugs?
☐	☐	5. Are you allergic to any drugs? What? ____________
☐	☐	6. Have you ever had a skin rash or other reaction to metal jewelry? To what? ____________
☐	☐	7. Are you allergic to any metals? What? ____________
☐	☐	8. Do you bleed excessively upon injury? ____________
☐	☐	9. Are you pregnant?
☐	☐	10. Have you ever been involved with dental/medical legal activity?

CIRCLE ANY OF THE FOLLOWING THAT YOU HAVE HAD OR NOW HAVE

A. AIDS	F. Epilepsy	K. High Blood Pressure	P. Rheumatic Fever
B. Arthritis	G. Glaucoma	L. Jaundice	Q. Sexually Transmitted Diseases
C. Asthma	H. Heart Murmur	M. Kidney Problems	R. Stroke
D. Cancer	I. Heart Problem*	N. Low Blood Pressure	S. Tuberculosis
E. Diabetes	J. Hepatitis	O. Nervous Breakdown or Psychiatric Therapy	T. Other Diseases*

*If you circled either I or T describe condition ______________________

Is there anything else we should know about your medical history? ______________________

____

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PERSON TO BE CONTACTED IN CASE OF EMERGENCY (OTHER THAN RELATIVE)

Name ______________________ Relationship ____________

Address ______________________

Telephone Home ____________ Work ____________

Signature ____________ Review by ____________ Date ____________