PATIENT REGISTRATION AND MEDICAL HISTORY

Date_____ Sex: M___ F___
Name_____ Home Phone_____
Single__ Married__ Divorced__ Separated__ Widowed__ Date of Birth_____
Address_____
City_____ State_____ Zip Code_____
E-mail Address_____
Employed by_____ Occupation_____
Business Address_____
Business Phone_____ Cell Phone_____
Social Security #_____
Spouse/Parent Name_____ Spouse/Parent Birthdate_____
Spouse/Parent Employed by_____ Occupation_____
Business Address_____ Business Phone_____
Name of Dental Insurance_____
Who is responsible for this account? _____
In case of emergency, who should be notified?_____ Phone_____
Whom can we thank for referring you?_____

MEDICAL HISTORY

Have you ever had any of the following?

YES	NO		YES	NO	
___	___	Heart Problems	___	___	Psychiatric Care
___	___	High Blood Pressure	___	___	Rheumatic Fever
___	___	Low Blood Pressure	___	___	Scarlet Fever
___	___	Circulatory Problems	___	___	Sinus Problems
___	___	Excessive Bleeding	___	___	Stroke
___	___	AIDS/HIV	___	___	Typhoid Fever
___	___	Anemia	___	___	Epilepsy
___	___	Asthma	___	___	Tuberculosis (TB)
___	___	Diabetes	___	___	Ulcer
___	___	Allergies	___	___	Cancer
___	___	Heart Murmur	___	___	Herpes
___	___	Mitral Valve Prolapse	___	___	Respiratory disease
___	___	Hepatitis	___	___	Hemophilia
___	___	Radiation Treatment	___	___	Chemical Dependency
___	___	Artificial Heart Valve or Joints	___	___	Back/Neck Problems

Do you have any drug allergies or have you ever had an adverse reaction to any medication?_____ If so, what_____
Are you taking any medication at this time?____ If so, what _____
_____
Are you under the care of a physican?_____ For what conditions?_____
Women, are you pregnant?_____ Are you nursing?_____
Is there anything else we should know about your medical history? _____