GLENDALE Family Dentistry
MakingPeopleSmile.com

PATIENT REGISTRATION

Office Use Only
ID:
Chart ID:

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: Address 2:

City/State/Zip: City/State/Zip:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec:

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Holder ◯ Insurance Policy Holder

Patient Information

Address: Address 2:

City/State/Zip: City/State/Zip:

Home Phone: Work Phone: Ext: Cellular:

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: Age: Soc. Sec:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Employer ID: Pref. Dentist:

Carrier ID: Pref. Hyg:

Pref. Pharmacy:

Section 3

Emergency Contact:

Emergency #:

Previous Dentist:

Confirm Pt. on Cell :

Referred by:

Primary Insurance Information

Name of Insured: Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City/State/Zip: City/State/Zip:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City/State/Zip: City/State/Zip:

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Medical History

Patient Name:

Date of Birth:

Today's 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 physicians care now?	Yes	No	If yes
Have you ever been hospitalized or had a major operation?	Yes	No	If yes
Have you ever had a serious head or neck injury?	Yes	No	If yes
Are you taking any medications, pills, or drugs?	Yes	No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	If yes
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	Yes	No	If yes
Are you on a special diet?	Yes	No	If yes
Do you use tobacco?	Yes	No	If yes

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following ?

Aspirin Penicillin Codeine Acrylic

Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes

Do you use controlled substances? Yes No If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Congenital Heart Disorder	Yes	No
Alzheimer's Disease	Yes	No	Convulsions	Yes	No
Anaphylaxis	Yes	No	Cortisone Medicine	Yes	No
Anemia	Yes	No	Diabetes	Yes	No
Angina	Yes	No	Drug Addiction	Yes	No
Arthritis/Gout	Yes	No	Easily Winded Emphysema	Yes	No
Artificial Heart Valve	Yes	No	Epilepsy or Seizures	Yes	No
Artificial Joint	Yes	No	Excessive Bleeding	Yes	No
Asthma	Yes	No	Excessive Thirst Fainting	Yes	No
Blood Disease	Yes	No	Spells/Dizziness Frequent	Yes	No
Blood Transfusion Breathing	Yes	No	Cough Frequent Headaches	Yes	No
Problems Bruise Easily	Yes	No	Genital Herpes Glaucoma	Yes	No
Cancer	Yes	No	Hay Fever	Yes	No
Chemotherapy	Yes	No	Heart Attack/Failure Heart	Yes	No
Chest Pains	Yes	No	Murmur	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Pacemaker	Yes	No

Heart Trouble/ Disease	Yes	No	Mitral Valve Prolapse	Yes	No
Hemophilia	Yes	No	Osteoporosis	Yes	No
Hepatitis A	Yes	No	Pain in Jaw Joints	Yes	No
Hepatitis B or C	Yes	No	Parathyroid Disease	Yes	No
Herpes	Yes	No	Psychiatric Care Radiation	Yes	No
High Blood Pressure	Yes	No	Treatments Recent Weight	Yes	No
High Cholesterol	Yes	No	Loss Renal Dialysis	Yes	No
Hives or Rash	Yes	No	Rheumatic Fever	Yes	No
Hypoglycemia	Yes	No	Rheumatism	Yes	No
Irregular Heartbeat	Yes	No	Scarlet Fever	Yes	No
Kidney Problems	Yes	No	Shingles	Yes	No
Leukemia	Yes	No	Sickle Cell Disease	Yes	No
Liver Disease	Yes	No	Sinus Trouble	Yes	No
Low Blood Pressure	Yes	No	Spina Bifida	Yes	No
Lung Disease	Yes	No	Stomach/Intestinal Disease	Yes	No
Mitral Valve Prolapse	Yes	No	Stroke	Yes	No
Osteoporosis	Yes	No	Swelling of Limbs Thyroid	Yes	No
Pain in Jaw Joints	Yes	No	Disease Tonsillitis	Yes	No
Parathyroid Disease	Yes	No	Tuberculosis	Yes	No
Psychiatric Care	Yes	No	Tumors or Growths Ulcers	Yes	No
Lung Disease	Yes	No	Venereal Disease	Yes	No
			Yellow Jaundice	Yes	No

Have you ever had any serious illness not listed? Yes No If yes

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:

Submit Form