



PATIENT REGISTRATION

Office Use Only
ID:
Chart ID:

First Name: _____ Last Name: _____ Middle Initial: _____
 Patient Is: Policy Holder Preferred Name: _____
 Responsible Party

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

Section 3

Employment Status: Full Time Part Time Retired	Emergency Contact:
Student Status: Full Time Part Time	Emergency #:
Employer ID: Pref. Dentist:	Previous Dentist:
Carrier ID: Pref. Hyg:	Confirm Pt. on Cell :
Pref. Pharmacy:	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:

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? None of these

Are you allergic to any of the following ?

Aspirin	Penicillin	Codeine	Acrylic	No Allergies
Metal	Latex	Sulfa Drugs	Local Anesthetics	

Other?

Do you use controlled substances? Yes No

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

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

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