E X C E L L E N C E   I N   D E N T I S T R Y

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PATIENT REGISTRATION AND MEDICAL HISTORY

(PLEASE PRINT)

Date: __________

Patient Name: ____

Last Name   First Name   Middle Initial   Preferred Name

Street Address: ____________________________ **City:** ___________________ **State:** ___________ **Zip:** _________

Sex: [ ] M [ ] F **Age:** _________ **Birthdate:** ____________ [ ] Single [ ] Married [ ] Widowed [ ] Separated [ ] Divorced

Home Phone: ______________________ **Cell Phone:** __________________________ **Email Address:** ______________________________

Employed by: ____ **Occupation:** ____

Business Address: ____ **Business Phone:** _______________________________________

Spouse Name: ____

Spouse Employed by: ____ **Occupation:** ____

Business Address: ____ **Business Phone:** ______________________________________

Who is responsible for this account? ________________________________ **Relationship to patient:** _________________________________

Social Security #: ____ **Spouse Social Security #:** ______________________________

Name of Dental Insurance: ______________________________________ **Group Number:** ______________________________________

In case of Emergency, who should be notified? ____ **Phone Number:** ___________________

Whom may we thank for referring you to our dental office? ____

MEDICAL HISTORY

Physician's Name: ____ **Date of last Physical:**__________________________

Have you ever had any of the following? (Check ones that apply):

[ ] Heart Problems
[ ] High Blood Pressure
[ ] Low Blood Pressure
[ ] Circulatory Problems
[ ] Nervous Problems
[ ] Radiation Treatment
[ ] Artificial Heart Valves or Joints
[ ] Recent Weight Loss
[ ] Back Problems
[ ] Diabetics
[ ] Respiratory Disease

[ ] Epilepsy
[ ] Headaches
[ ] Hepatitis, Jaundice or Liver Disorder
[ ] Cancer
[ ] Psychiatric Care
[ ] Chronic Diarrhea
[ ] Allergies to Anesthetics
[ ] Allergies to Medicine or Drugs
[ ] General Allergies
[ ] Blood Disorders
[ ] Arthritis

[ ] Special Diet
[ ] Swollen Neck Glands
[ ] Rheumatic Fever
[ ] Sinus Problems
[ ] "A.I.D.S." or other Immunosuppressive Disorders
[ ] Stroke
[ ] Ulcer
[ ] Venereal Disease
[ ] Chemical Dependency
[ ] Hemophilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____________ **If so, what?** _______________

____

Have you ever responded adversely to medical or dental treatment? ____

Are you taking any medication at this time? ______________ **If so what?** ____

Are you under the care of a physician? [ ] YES [ ] NO

For what condition? ____

If patient is a child, what is his/her weight? _____________________

(Women) Do you suspect that you are pregnant? [ ] YES [ ] NO **Are you nursing?** [ ] YES [ ] NO

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

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The above information is accurate and complete to the best of my knowledge and is only for the use in my treatment, billing and processing of insurance for benefits for which I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: ____ **Signature:** ____