PATIENT REGISTRATION

Patient Name____

(Last) (First) (Middle) (Nickname or preferred)

Address____

City ______________________________ State _______________ Zip_____________________________

Home Number: _______________ Work:_________________Cell: _________________________________

Birthdate: ________________ Age: _______ Sex: _______ SS# ___________________________________

Email _______________________________________ Marital Status _________________________________

Employer:____

Insurance? Yes / NO Insurance Company ____

Who is responsible for the bill? ____

Pharmacy Preference ____

How did you hear about our practice? ____

Are you pleased with your smile/teeth? ____

What would you change? ____

Why did you leave your last dentist? ____

MEDICAL HISTORY

Name of physician ____

Office phone ____

Address of your physician ____

1. Are you in good health? Yes / No / Unsure
2. Have you ever been hospitalized, had a major operation or serious illness? Yes / No / Unsure (If yes, explain)

____

3. Are you currently receiving treatment by your doctor? Yes / No

(If yes, explain) ____

4. Date of your last visit to your doctor ____

Reason ____

5. Please circle any illness or conditions you have had or been treated for:

Diabetes Stroke	TMJ Problems Abnormal Bleeding	Venereal Disease Cancer
Kidney Disease	Heart Disease/Murmur	AIDS/HIV/Hepatitis
Jaw Surgery	High Blood Pressure	Tuberculosis
Injuries to Face or Jaws	Heart Valve Surgery	Spinal Surgery
Arthritis	Joint Replacement	Artificial Pins/Rods/Screws/Plates
Rheumatic Heart Disease	Rheumatic Fever	

6. Do you use tobacco now? Y N

Type and Daily Amount ____

Did you use tobacco in the past? Y N

Type and Daily Amount ____________________________________

7. Please list all prescription medications.

Medications and Frequency	Dose
______________________________	___________________________
______________________________	___________________________
______________________________	___________________________
______________________________	___________________________
______________________________	___________________________
______________________________	___________________________

8. Please list any other medications (prescription or over the counter) that you have used recently:

____

9. Do you have any allergies to any medications? Please List:

____

____

____

10. Women: Are you now pregnant? Y N Unsure

____ ________________

Patient (or guardian) Signature Date

____ ________________

DDS Reviewed History