



Thank You for selecting our dental team

We strive to meet all your healthcare needs,
please fill out this form

Patient Registration Form

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Birth Date: _____ E-Mail: _____

Sex: Male _____ Female _____ Social Security Number: _____ Drivers Lic: _____

Primary Insurance: Name of Insured: _____ Employer: _____

Insured Soc. Sec.: _____ Insurance Company: _____

Secondary Insurance: Name of Insured: _____ Employer: _____

Insured Soc. Sec.: _____ Insurance Company: _____

Emergency Contact Person: _____ Phone Number: _____

Medical Doctor: _____ Name/Phone of Clinic: _____



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Medical History

Patient Name _____

Birthdate ____/____/____

Are you under a physician's care now? Yes No If Yes, please explain _____
 Have you been hospitalized or
 had a major operation? Yes No If Yes, please explain _____
 Have you ever had a serious head or neck injury? Yes No If Yes, please explain _____
 Are you taking any medications, pills or drugs? Yes No If Yes, please list _____
 Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
 Are you on a special diet? Yes No _____
 Do you use a controlled substance? Yes No _____
 Do you use tobacco? Yes No _____

~Women are you:

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin	Yes	No	Acrylic	Yes	No	
Metal	Yes	No	Penicillin	Yes	No	
Latex	Yes	No	Codeine	Yes	No	
Local Anesthetics	Yes	No	Other	Yes	No	If Yes, please list _____

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

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy/Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestine	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joint	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Veneral Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatment	Yes	No	Yellow Jaundice	Yes	No
Convulsions			Heart trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If Yes, please explain _____

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 _____