

# PATIENT REGISTRATION AND MEDICAL HISTORY

Date \_\_\_\_\_ (PLEASE PRINT) Home Phone \_\_\_\_\_

Patient \_\_\_\_\_  
Last Name First Name Initial Preferred Name

E-mail Address: \_\_\_\_\_ Cell Phone \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Spouse Name \_\_\_\_\_ Spouse Birthdate \_\_\_\_\_

Spouse Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ Spouse's Social Security # \_\_\_\_\_

Name of Dental Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_

In case of emergency, who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of Last Physical \_\_\_\_\_

Have you ever had any of the following? (check boxes that apply):

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Heart Murmur  | <input type="checkbox"/> Epilepsy  | <input type="checkbox"/> Special Diet        |
| <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Headaches   | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Low Blood Pressure  | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease                  | <input type="checkbox"/> Rheumatic Fever     |
| <input type="checkbox"/> Circulatory Problems  | <input type="checkbox"/> Cancer  | <input type="checkbox"/> Sinus Problems      |
| <input type="checkbox"/> Nervous Problems  | <input type="checkbox"/> Psychiatric Care                                      | <input type="checkbox"/> AIDS/HIV            |
| <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> premed | <input type="checkbox"/> Thyroid Disease     |
| <input type="checkbox"/> Artificial Heart Valves or Joints <input type="checkbox"/> premed | <input type="checkbox"/> Allergies to Anesthetics                              | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Recent Weight Loss  | <input type="checkbox"/> Allergies to Medicine or Drugs                        | <input type="checkbox"/> Ulcer               |
| <input type="checkbox"/> Back Problems   | <input type="checkbox"/> General Allergies                                     | <input type="checkbox"/> Venereal Disease    |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Blood Disease   | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Hemophilia          |
| <input type="checkbox"/> Latex Allergy   | <input type="checkbox"/> Epinephrine (Allergy/Reaction)                        |  |

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 conditions? \_\_\_\_\_

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

(Woman) 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? \_\_\_\_\_

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. 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 \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I, the undersigned, have insurance with \_\_\_\_\_  
*Name of Insurance Company(ies)*

and assign directly to Dr. \_\_\_\_\_ all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

*Date*

*Signature*

**MINOR/CHILD CONSENT**

I, being the parent or guardian of \_\_\_\_\_ do hereby request  
*Name of minor/child*

and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

*Date*

*Signature of Insured/Guardian*

**FINANCIAL AGREEMENT**

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

*Date*

*Signature of Insured/Guardian*

**MEDICAL HISTORY UPDATE**

Has there been any change in your health since your last dental appointment?  Yes  No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what \_\_\_\_\_

*Date*

*Patient Signature*

*Date*

*Dentist Signature*

**MEDICAL HISTORY UPDATE**

Has there been any change in your health since your last dental appointment?  Yes  No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what \_\_\_\_\_

*Date*

*Patient Signature*

*Date*

*Dentist Signature*