WELCOME!

Patient Registration and Medical History

Date_____

Patient Name_____ **Home Phone**_____
(First) (M.I.) (Last)
Street Address_____**Apt.**_____

City_____ **State**_____ _____**Zip** _____

Sex: ☐ **M** ☐ **F** **Age**_____ **Birthdate**___/___/___ ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Separated** ☐ **Divorced**

Parent/Responsible Party Name_____ **Business Phone** _____
(If applicable)
Employer_____ **Occupation** _____

Cell Phone _____ **E-Mail** _____

Patient SS#_____ - ____ - _____ **Parent/Responsible Party SS#**_____ - _____ - _____**D.O.B** ____/_____/_____

Dental Insurance Carrier_____ **Group Policy #**___ _____

How did you hear about us?_____ _____ _____

Reason for Appoinment_____ _____

Medical History

Physician's Name_____ Last Seen_____

Have you ever had any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Heart Murmur	☐	☐	Circulation Problems	☐	☐	Cancer
☐	☐	Artificial Heart Valves or Joints	☐	☐	Blood Diseases	☐	☐	Seizures
☐	☐	Rheumatic Fever	☐	☐	Asthma	☐	☐	Nerve Problems
☐	☐	Mitral Valve Prolapse	☐	☐	Other Respiratory Diseases	☐	☐	Kidney Problems
☐	☐	Heart Attacks	☐	☐	Diabetes	☐	☐	Stroke
☐	☐	Blood Pressure Problems	☐	☐	Hepatitis or Liver Problems	☐	☐	Thyroid Disease

Do You Have any drug allergies or have you ever had an adverse reaction to any medication?_____ If so, what_____

_____.

List any current Medications: _____.

(Women) Are You Pregnant? ☐ Yes ☐ No Are You Nursing? ☐ Yes ☐ No

Dental History

Last Visit_____ for What_____

Prior Extractions_____ Use Local Anesthesia_____

Prior Complications_____ Use Analgesia_____

General Appearance

Face/Neck_____ Lips/ Cheeks_____

Palate_____ Floor of Mouth/Tongue_____

Gingiva_____ Teeth_____

Signature_____ **Reviewed by**_____