

Registration Form and Medical History

PERSONAL INFORMATION

PATIENT'S LAST NAME FIRST INT.

HOME ADDRESS

STREET CITY/STATE/ZIP

PHONE CELL PHONE PAGER

EMAIL ADDRESS

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME

RELATIONSHIP PHONE

WORK INFORMATION

EMPLOYER

BUSINESS ADDRESS CITY/STATE/ZIP

PHONE CELL PHONE PAGER

EMAIL ADDRESS

DENTAL INSURANCE INFORMATION

EMPLOYER NAME

EMPLOYEE NAME DATE OF BIRTH

INSURANCE COMPANY POLICY NUMBER

EMPLOYEE SOCIAL SECURITY NUMBER

RELEASE

I authorize the dentist to perform diagnostic procedures and treatments as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advise, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I acknowledge that I am responsible for all costs of dental treatment. I attest to the accuracy of the above information.

I understand I will be charged for any missed or failed appointments without 48 hours prior notice. Charges will vary according to length of appointment time scheduled.

SIGNATURE

DATE

REVIEWED AND VERIFIED BY STAFF

DATE

MEDICAL HISTORY

1. Has your medical history changed within the last 2 years? Yes No

If Yes, for what? _____

PHYSICIAN NAME PHONE

ADDRESS

2. List any medications you are currently taking or have taken in the past two years _____

3. Circle any of the following that you are allergic to or have had reactions to:
Local anesthetics like Novocaine Penicillin or other antibiotics — Aspirin Sulfa Drugs Iodine Latex Other _____

Circle any of the following you have had or have currently

- | | |
|-----------------------------------|----------------------------------|
| Abnormal Bleeding | Heart Surgery |
| AIDS/HIV | Hemophilia |
| Allergies/Hives or Skin Rash | Hepatitis A (Infectious) |
| Anemia | Hepatitis B (Serum) |
| Arthritis or Rheumatism | High Blood Pressure |
| Artificial Heart Valve | Kidney Trouble |
| Artificial Joints or implants | Liver Disease or Jaundice |
| Asthma or Hay Fever | Low Blood Pressure |
| Blood Transfusion | Mitral Valve Prolapse |
| Bruise Easily | Nervousness |
| Chemotherapy | Pacemaker |
| Cold Sores | Persistent cough |
| Congenital Heart Lesions | Psychiatric Treatment |
| Cortisone Medicine | Rheumatic Heart disease or fever |
| Diabetes or Hypoglycemia | Sexually Transmitted Disease |
| Drug Addiction | Sickle Cell Disease |
| Emphysema | Sinus Trouble |
| Epilepsy or Seizures | Stroke |
| Fainting or Dizzy Spells | Thyroid Problems |
| Genital Herpes | Tuberculosis |
| Glaucoma | Ulcers |
| Heart defect or heart murmur | Valvular Heart Infection |
| Heart Disease/Heart Attack/Angina | X-Ray/Cobalt Treatment |

Do you have any problem, disease or condition NOT listed above? _____

Date of last physical examination _____