PATIENT REGISTRATION

WELCOME TO OUR OFFICE!

DATE			
PATIENT NAME		PREFERRED NAME	
ADDRESS			
CITY	STATE	ZIP	
Cell Phone #	Home Phone #	Work Phone #	
EMAIL ADDRESS (FOR CONFIRMATIONS)			
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED

DENTAL INSURANCE

INS. COMPANY NAME	
INS. CO. MAILING ADDRESS	
INS. CO. TELEPHONE #	
GROUP #	SUBSCRIBER ID #
SUBSCRIBER NAME	EMPLOYER
SUBSCRIBER BIRTH DATE	
SUBSCRIBER SOCIAL SECURITY #	

HEALTH HISTORY

1. Person to contact in case of an emergency_____ Phone #: _____

2. When was your last medical examination? _____ Physician's Name: _____

3 Are you aware of being allergic to or have you ever reacted adversely to any medication or substance?..... YES NO
If yes, please list: _____

4. Are you now taking any medication, drugs or pills?..... YES NO
If yes, please list: _____

_____

5. Indicate which of the following you have at present or have ever had. ***Circle "yes" or "no" to each item.***

High Blood Pressure	YES	NO	Thyroid Problems	YES	NO	Drug Habits	YES	NO
Heart Issues	YES	NO	Breathing Issues	YES	NO	Hepatitis? Type_____	YES	NO
Heart Murmur	YES	NO	Tuberculosis	YES	NO	Venereal Disease	YES	NO
Mitral Valve Prolapse	YES	NO	Asthma	YES	NO	AIDS / HIV Positive	YES	NO
Rheumatic Fever	YES	NO	Diabetes	YES	NO	Blood Transfusion	YES	NO
Artificial Joints (hip, knee, etc.)	YES	NO	Gastric Ulcers	YES	NO	Anemia	YES	NO
Arthritis/Rheumatism	YES	NO	Liver Disease	YES	NO	Chemo/Radiation Therapy	YES	NO
Stroke	YES	NO	Kidney Trouble	YES	NO	Fainting or Dizzy Spells	YES	NO
Glaucoma	YES	NO	Cosmetic Surgery	YES	NO	Epilepsy or Seizures	YES	NO

6. Do your ankles swell during the day?..... YES NO
7. Has your medical doctor ever said you have a cancer or tumor?..... YES NO
8. Do you have or have you had any disease, condition, or problem not listed above?..... YES NO
If yes, please list: _____

FOR WOMEN ONLY;

Are you pregnant? [] Yes: due what month? [] No

Are you nursing? [] Yes [] No

Are you taking birth control pills? [] Yes [] No