PATIENT REGISTRATION AND MEDICAL HISTORY

Date (PLEASE PRINT) Home Phone _____

Patient _____
Last Name First Name Initial Preferred Name

Street Address _____ City _____ State _____ Zip _____

Sex ◯ M ◯ F Age _____ Birthdate _____ ◯ Single ◯ Married ◯ Widowed ◯ Separated ◯ Divorced

Employed by _____ Occupation _____

Employer's Address _____ Business Phone _____

Spouse Name _____

Spouse Employed by _____ Employer's Address _____

Insured Employee's Birthdate _____ Business Phone _____

Who is responsible for this account? _____ Relationship to Patient _____

Patient's Social Security # _____ Insured Employee's Social Security # _____

Name of Dental Insurance Company _____ Group Number _____

Mailing Address of Insurance Co. _____

Nearest Relative (with whom I am not living) to notify in emergency _____ 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):

- ☐ Heart Problems
- ☐ Blood Pressure Problems
- ☐ Circulatory Problems
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Artificial Heart Valves or Joints
- ☐ Back Problems
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ General Allergies
- ☐ Blood Disease
- ☐ Arthritis
- ☐ Stroke
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ "A.I.D.S." or Other Immunosuppressive Disorders
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Hemophilia

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

Have you ever had a bad experience with dental treatment? _____

Are you taking medication at this time? _____ If so, what _____

Are you under the care of a physician? ◯ Yes ◯ No

For what conditions? _____

(Women) Do you suspect that you are pregnant? ◯ 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. If payment is not received from the patient/guarantor/customer within sixty (60) days from the date of last change(s) or within thirty (30) days after insurance check is received by customer/guarantor/patient, the patient/guarantor/customer will be responsible & liable for all collection or attorney fees incurred while enforcing collection of said account. An interest rate of 12% per annum (1% per month) will be attached to all balances that are over 60 days old.

Date _____ Signature _____