PATIENT REGISTRATION AND HEALTH HISTORY

Patient Name_____ Middle Initial_____ Preferred Name_____

Marital Status_____ Student: Y N Sex: M F Date of Birth_____ Age_____

Driver's License #_____ SS #_____ Email Address_____

Address_____ City_____ State_____ Zip_____

Cell #_____ Alt #_____ How Did You Hear About Us?_____

Occupation_____ Employer_____ Employer Phone #_____

INSURANCE INFORMATION: Person Responsible For Balances_____ DOB_____ SS#_____

Is Patient Covered By Insurance? Y N Person's Name Who Holds Policy_____ DOB_____

Dental Carrier_____Employer_____ ID or SS#_____ Grp #_____

Patient's Relationship To Insured_____ Ins. Provider Customer Phone #_____

Does Patient Have Secondary Ins? Y N Person's Name Who Holds Policy_____ DOB_____

Dental Carrier_____Employer_____ ID or SS#_____ Grp #_____

Patient's Relationship To Insured_____ Ins. Provider Customer Phone #_____

In Case of Emergency Name of Friend or Relative (not living at same address)_____

Phone #_____ Relationship To Patient_____ Alt #_____

HEALTH HISTORY:

Please CHECK any of the following that apply to you: (Use BACK for explanation if necessary)

__Allergies (Seasonal / Hay Fever)
__Anemia
__Artificial Heart Valve (see pre-med)
__Artificial Joints (see pre-med below)
__Asthma
__Blood Disease
__Bruise Easily
__Cancer - Type_____
__Chemotherapy
__Diabetes
__Dizziness
__Drug Addiction
__Emphysema / COPD
__Excessive Bleeding
__Fainting
__Glaucoma
__Head Injuries
__Heart Conditions
__Heart Disease
__Heart Murmur
__Hepatitis A,B or C – Which?_____
__High Blood Pressure
__HIV / AIDS
__Jaundice
__Kidney Disease
__Liver Disease
__Mental / Depression
__Mitral Valve Prolapse (see pre-med)
__Nervous
__Pacemaker
__Radiation-Where?_____
__Respiratory Problems
__Rheumatic Fever (see pre-med)
__Rheumatism
__Scarlet Fever (see pre-med below)
__Seizures / Epilepsy
__Stomach Problems
__Stroke
__Thyroid Disease
__Tobacco/Vape - see below
__Tuberculosis
__Ulcers
__Venereal Disease
__**OTHER (Please List):**
_____
_____
_____

For WOMEN Only:
__Birth Control Pills
__Breast Feeding
__Pregnant – Circle Below
1-3mos 3-6mos 6-9mos

DO YOU Smoke Tobacco? Y N How Long?_____ Use Tobacco Products? Y N How Long?_____ Vape? Y N How Long?_____

DO YOU Take a Pre-Medication? Y N If so, what for?_____ Which Rx?_____

What Medications Are You Currently Taking:
(Please Use Back If Necessary) >

_____

Do you have an allergy to any of the following:
__Aspirin __Erythromycin __Local Anesthesia __Penicillin
__Codeine __Latex __Nitrous Oxide __Sulfa
__Other:_____

Are you under a Physician's Care? Y N What For?_____

Family Physician/PCP_____ Phone Number_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the Dentist. I understand that I am financially responsible for any balance. I also authorize DECATUR FAMILY DENTISTRY or my insurance company to release any information required to process my claim(s).

Patient/Guardian Signature_____ Date_____