REGISTRATION

Patient's name _____
Last First M.I.

Birth date _____ Age _____ Date _____

☐Single ☐Married ☐Long-Term Partner ☐Separated ☐Widowed ☐Divorced

Name of spouse/partner _____

If a child, parent's name _____

Address _____

City _____ State _____ Zip _____

Business address _____

Telephone: Home _____ Business _____

Patient employed by _____

Present position _____ How long held _____

Spouse/partner employed by _____

Present position _____ How long held _____

Referred by _____

Who will pay this account _____

Purpose of visit? _____

Patient's Social Security number _____

[redacted] _____

Spouse/partner's Social Security number _____

Spouse/partner's birth date _____

Name and address of dental insurance company:

Primary _____ Secondary _____

_____ _____

Policy # _____ Policy # _____

Item 15

Date of last medical examination _____

Do you have or have you ever had:	Yes	No
Anemia	_____	_____
Diabetes	_____	_____
Hepatitis	_____	_____
Allergies	_____	_____
To penicillin	_____	_____
To local anesthetic	_____	_____
Abnormal heart condition	_____	_____
Abnormal bleeding from a cut	_____	_____
Rheumatic fever	_____	_____
Heart murmur	_____	_____
Are you under the care of a physician now	_____	_____

Name of physician _____

Telephone number _____

Are you taking any medication	_____	_____

If so, what _____

_____

Other physical conditions we should be aware of _____

_____

_____

Blood pressure (if known) ..... S _____/ D_____ / _____

Signature _____ Date _____

Date	Service rendered	Charge	Credit	Balance