REGISTRATION HISTORY

DATE_____AGE____

PATIENTS NAME_____ M F DATE OF BIRTH_____

IF A CHILD, RESPONSIBLE PARTY'S NAME _____S.S#_____

STREET ADDRESS_____PHONE_____

CITY_____STATE_____ZIP_____

PATIENT EMPLOYED BY_____BUSINESS PHONE_____

BUSINESS ADDRESS_____

OCCUPATION_____

PURPOSE OF THIS APPOINTMENT_____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED_____PHONE_____

WHO WILL PAY THIS ACCOUNT_____

METHOD OF PAYMENT _____ CASH _____ CHECK _____ CHARGE _____

DO YOU HAVE INSURANCE THAT MAY COVER ANY PART OF OUR PROFESSIONAL SERVICES? YES_____ NO_____

IF INSURANCE COVERED, SOCIAL SECURITY NO. OF PERSON COVERED_____D.O.B._____

WHOM MAY WE THANK FOR REFERRING YOU_____

SINGLE_____MARRIED_____DIVORCED_____WIDOWED_____SEPARATED_____

NAME OF SPOUSE_____

SPOUSE EMPLOYED BY_____PHONE_____

BUSINESS ADDRESS_____

PRESENT POSITION_____SPOUSE'S S.S.#_____D.O.B._____

MEDICAL HISTORY

PHYSICIAN'S NAME_____DATE OF LAST PHYSICAL_____

HAVE YOU BEEN HOSPITALIZED IN THE LAST 5 YEARS? _____ IF SO, FOR WHAT_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK YES OR NO)

YES	NO		YES	NO	
☐	☐	Heart Problems	☐	☐	Heart Murmur
☐	☐	High Blood Pressure	☐	☐	Rheumatic Fever
☐	☐	Stroke	☐	☐	"A.I.D.S."
☐	☐	Diabetes	☐	☐	HIV POSITIVE
☐	☐	Respiratory Disease	☐	☐	Hepatitis, Jaundice or Liver Disease
☐	☐	Sinus Problems	☐	☐	Venereal Disease
☐	☐	Epilepsy	☐	☐	Chemical Dependency
☐	☐	Psychiatric Care	☐	☐	Hemophilia
☐	☐	Ulcer	☐	☐	Abnormal Bleeding From a Cut
☐	☐	Tuberculosis			

	YES	NO
Are You Allergic To:		
Penicillin	☐	☐
Local Anesthetic	☐	☐
Medication or Drugs	☐	☐

Indicate which ones _____

_____

Women: Are You Pregnant	☐	☐
Oral Contraceptive	☐	☐

ARE YOU TAKING ANY MEDICATION? _____ PLEASE LIST _____

OTHER PHYSICAL CONDITIONS (NOT LISTED ABOVE)_____

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.

DATE_____SIGNATURE_____