# Patient Registration and Medical History Form

Date _____ (please print) Home Phone (____)_____

Patient _____
Last Name First Name Initial Preferred Name

Street Address _____ City _____State ___ Zip _____

Email address _____ Cell Phone (____) _____

Sex: M___ F____ Age_____ Birthdate_____

Single___ Married___ Widowed___ Separated ___Divorced ___

Employed by _____

Occupation _____

Business Address: _____

Business phone (____)_____

Spouse/Parent Name_____

Spouse/Parent Birthdate _____

Spouse/Parent Employed by _____

Occupation _____

Business Address: _____

Business phone (____)_____

Who is responsible for this account? _____Relationship to Patient _____

Social Security # _____

Spouse/Parent's Social Security # _____

Name of Dental Insurance Company _____

Group Number _____

In case of emergency, who should be notified? _____

Emergency contact 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 all boxes that apply):

__ Heart Problems
__ High Blood Pressure
__ Low Blood Pressure
__ Circulatory Problems
__ Nervous Problems
__ Radiation Treatment
__ Artificial Heart Valves or Joints
__Recent Weight Loss
__ Back Problems
__ Diabetes
__ Respiratory Disease
__Epilepsy
__ Headaches
__ Hepatitis, Jaundice or liver disease
__ Cancer
__ Psychiatric Care
__ Chronic Diarrhea
__ Allergies to Anesthetics
__ Allergies to Medicine or drugs
__ General Allergies
__ Blood Disease
__ Arthritis
__Special Diet
__ Swollen Neck Glands
__ Rheumatic Fever
__ Sinus Problems
__ HIV/AIDS or Other Immunosuppressive disorders
__ Stroke
__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 responded adversely to medical or dental treatment?
_____

Are you taking any medication at this time? _____

If so, what _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine) Yes ____ or No _____

Are you under the care of a physician? Yes ____ No _____

For what conditions _____

If patient is a child, what is his/her weight? _____

(Woman) Do you suspect that you are pregnant? Yes _____ or No _____

Are you nursing? Yes _____ or 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.

Date _____ Signature _____