PATIENT REGISTRATION

Name ____
Last First MI

Address ____
Number, Street P.O. Box City State Zip

Home phone ________________ Cell phone ________________ Business phone ________________

Email ______________________ Choice of Contact: Phone Email Text

Date of Birth ________________ Sex ________ Height ________ Weight ________

Occupation ________________ Employer ________________

Social Security ________________ Single ______ Married ______ Name of Spouse ________________

Closest Relative ________________ Relationship ________ Phone ________________

If you are completing this form for another person, what is your relationship to this person? ________________

Referred by ____

Medical History

1. What is your general health?
   good fair poor

	(Y)	(N)
2. Are you being treated by a physician now?	( )	( )
3. Has there been any change in general health in the past year?	( )	( )
4. Have you ever been hospitalized?	( )	( )
5. Have you ever had surgery?	( )	( )
6. Have you ever had a blood transfusion?	( )	( )
7. Have you ever had an injury to your jaw or face?	( )	( )
8. Have you ever been treated for any growth or tumor in your body?	( )	( )
9. Are you ever short of breath on mild exertion?	( )	( )
10. Do your ankles ever swell?	( )	( )
11. Is it likely that your pregnant?	( )	( )
12. Are you taking any drugs or medications?	( )	( )

If so, what?

____

Explain ____

13. Have you had any of the following?
    (please circle)

heart disease	liver disease	hepatitis Type A B C
chest pain	arthritis	bleeding problems
asthma	seizures	high blood pressure
anemia	heart murmur	stroke
tuberculosis	diabetic	venereal disease
ulcer	HIV positive	thyroid problem
rheumatic fever	AIDS	kidney problem
scarlet fever	artificial joint	implant
lung disease	jaundice	cancer
hearing problem		psychiatric problem

Do you require Pre Med? ________________

14. Are you allergic to any medications? ________________

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15. Are you a Smoker? Yes or No
    If so approximately how many per day? ______

16. Do you take Aspirin on a daily basis or blood thinner? _____

Dental History

1. What is the purpose of your visit? ____
2. Do you have any of the following? ( ) Cavities ( ) Sore Gums ( ) Bleeding Gums ( )Bone Loss ( ) Loose Teeth
3. How often do you brush your teeth? ________________ Floss? ________________
4. Have you ever had difficult extractions? ____
5. Have you had any unpleasant dental experiences? ____
6. What concerns you most about your mouth or oral health? ____
7. Are you difficult to anesthetize (numb)? ____
8. When was your last dental visit? ________________ Purpose ________________

Comments ____

Signature: ________________________ *Date:* ________________________