PATIENT REGISTRATION

Name _____
Last First M.I. Preferred

Address _____
Number, Street, PO. Box, Apt # City State Zip

Home phone _____ Cell _____ Other _____

E-Mail _____ Prefered Method of Contact: ( ) Phone ( ) Text ( ) Email

Date of Birth _____ Sex _____ Height _____ Weight _____

Employer _____ Occupation _____

Social Security # _____ Single ___ Married ___ Name of Spouse _____

Emergency Contact: _____ Relationship _____ Phone _____

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

Referred by: _____ (or) Google Website Mailout Newspaper Phone Book Insurance

MEDICAL HISTORY

1. What is your general health? ( ) Good ( ) Fair ( ) Poor

2. Are you allergic to any medications? ( ) yes ( ) no

_____

		(Y)	**(N)**
3.	Are you being treated by a physician now?	( )	( )
4.	Has there been any change in your general health over the past year?	( )	( )
5.	Have you ever been hospitalized?	( )	( )
6.	Have you ever had surgery?	( )	( )
7.	Have you had a blood transfusion?	( )	( )
8.	Have you had an injury to your face or jaw?	( )	( )
9.	Have you ever been treated for a growth or tumor in your body?	( )	( )
10.	Are you ever short of breath on mild exertion?	( )	( )
11.	Do your ankles ever swell?	( )	( )
12.	Is it likely that you are pregnant?	( )	( )
13.	Are you a smoker? # Per Day _____	( )	( )
14.	Do you take Aspirin or a Blood Thinner daily?	( )	( )
15.	Do you require Pre Med? _____	( )	( )

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

AIDS	HIV positive
Anemia	Implant
Arthritis	Jaundice
Artificial joint	Kidney problem
Asthma	Liver disease
Bleeding problem	Lung disease
Cancer	Psychiatric problem
Chest pain	Rheumatic fever
Diabetic	Scarlet fever
Hearing problem	Seizures
Heart disease	Stroke
Heart murmur	Thyroid problem
Hepatitis Type A B C	Tuberculosis
High blood pressure	Ulcer

17. Are you taking any drugs or medications? **(Y)** **(N)**
(Continue on back if required) ( ) ( )

_____

_____

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. When was your last dental visit? _____ Purpose _____

Comments _____

_____

Signature: _____ Date: _____