

PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ (PLEASE PRINT) Home Phone (_____) _____

Patient _____
Last Name First Name Middle Initial Preferred Name

Street Address _____ City _____ State _____ Zip _____

E-mail _____ Cell Phone (_____) _____

Sex M F Age _____ Birthdate _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years

Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School 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? _____ 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 boxes that apply):

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Artificial Heart Valves or Joints, Screws, etc. | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Special Diet |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Swollen Neck Glands |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Venereal Disease |

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia? Yes No

If so, what? _____

Have you ever responded adversely to medical or dental treatment? Yes No

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 No

Are you under the care of a physician? Yes No For what conditions? _____

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

(Women) Do you suspect that you are pregnant? Yes No Due date _____

Are you nursing? Yes No Taking birth control pills? Yes No

Is there anything else we should know about your medical history? _____

