Patient Registration

Name:	Sex: M F	Birth Date:	SS#
Address:	City:	State:	Zip:
Home#	Cell#	Work#	
Your Employer:	Driver's Lic#		Issue State:
Please Circle One: single married separated widowed		Email:	
Name of Spouse(parent if minor):		Birth Date:	SS#
Employer:	Cell#	Work#	
Emergency contact name:	Home#	Cell#	

Dental Insurance Information (Primary Carrier)

Insured's Name	DOB	SS#
Insured's Employer		
Insurance Co.		
Insurance Co. Address		
Phone #		
Group #	Local #	

Complete this for Secondary Coverage

Insured's Name	DOB	SS#
Insured's Employer		
Insurance Co.		
Insurance Co. Address		
Phone #		
Group #	Local #	

It is important that we know about your medical and dental history. The information is strictly confidential and will not be released to anyone, thank you.

Medical History	**YES**	**NO**	If yes ,please explain
Do you have any current health problems?	❒	❒	
Are you under a Physician's care now?	❒	❒	
Are you currently taking any medications?	❒	❒	

Date of last dental visit:_____

	Yes	No		Yes	No		Yes	No
Aids	❒	❒	Excessive Bleeding	❒	❒	Pacemaker	❒	❒
Anemia	❒	❒	Fainting	❒	❒	Pen Fen(if taken > 1 month)	❒	❒
Allergies	❒	❒	Glaucoma	❒	❒	Pregnant-currently due date _____	❒	❒
Angina Pectoris	❒	❒	Hay Fever	❒	❒	Psychiatric Treatment	❒	❒
Arthritis	❒	❒	Heart Disease/Attack	❒	❒	Radiation Treatment	❒	❒
Artificial Heart Valve	❒	❒	Heart Murmur	❒	❒	Respiratory Problems	❒	❒
Artificial Joints	❒	❒	Heart Surgery	❒	❒	Rheumatism	❒	❒
Asthma	❒	❒	Hepatitis A	❒	❒	Scarlet Fever	❒	❒
Blood Disease	❒	❒	Hepatitis B	❒	❒	Sinus Problems	❒	❒
Bruise Easily	❒	❒	High Blood Pressure	❒	❒	Stomach Problems	❒	❒
Cancer	❒	❒	HIV Positive	❒	❒	Stroke	❒	❒
Chemotherapy	❒	❒	Jaundice	❒	❒	Thyroid Disease	❒	❒
Congenital Heart Lesions	❒	❒	Jaw Joint Pain	❒	❒	Tuberculosis	❒	❒
Dizziness	❒	❒	Kidney Disease	❒	❒	Ulcers	❒	❒
Diabetes	❒	❒	Liver Disease	❒	❒	Venereal Disease	❒	❒
Drug Addiction	❒	❒	Low Blood Pressure	❒	❒	Nervous Disorders	❒	❒
Emphysema	❒	❒	Migraines	❒	❒		❒	❒
Epilepsy	❒	❒	Mitral Valve Prolapse			Other _____		

Are you allergic or have reacted adversely to any of the following medication

	Yes	No		Yes	No		Yes	No
Aspirin	❒	❒	Percodan	❒	❒	Erythromycin	❒	❒
Darvon	❒	❒	Local Anesthetic	❒	❒	Valium	❒	❒
Nitrous Oxide	❒	❒	Codeine	❒	❒	Penicillin	❒	❒

Family Physician _____ Phone Number _____

Is there any medical/dental information that you feel I should know about? _____

_____

Consent for Treatment: The undersigned hereby authorizes Doctor to take X-Rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to preform any and all forms of treatment, medication and therapy, that may be indicated. I also understand that the use of anesthetic agents embodies a certain risk. The above information provided is an accurate representation of my health and all prescription medicines are listed. I understand that dental treatment in and of it self embodies a certain risk and that additional treatment other than what initially prescribed may be required to help save my teeth.

Patient Signature (Parent of Child) _____ Date: _____ Dentist Signature: _____