

REGISTRATION FORM / MEDICAL-DENTAL HISTORY

Patient Registration For: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Business Telephone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status: S M D W Spouse's Name \_\_\_\_\_

Employer's Name & Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Will you receive calls at work? \_\_\_\_\_

How would you prefer to be addressed? \_\_\_\_\_

If Minor, Name of Guardian, Address & Telephone \_\_\_\_\_

Person Responsible for Fee (if other than patient) \_\_\_\_\_

Whom may we thank for referring you to this office? \_\_\_\_\_

Name of Dental Insurance Company \_\_\_\_\_

Subscriber's Name & Relationship to Patient \_\_\_\_\_

Subscriber's SSN: \_\_\_\_\_ Subscriber's Date of Birth: \_\_\_\_\_

Group Policy # \_\_\_\_\_ Individual Policy # \_\_\_\_\_

Whom should we contact in case of emergency - Name & Telephone \_\_\_\_\_

MEDICAL HISTORY

Please answer all the questions on this history form in pen. The questions asked relate directly to the safe and effective treatment you are to receive. Please answer honestly to the best of your ability. If a question does not relate to you or your medical condition, please write "N/A" (not applicable) in the space provided.

*All information you supply to the office on this form, the subsequent interview by the dentist and received from your physician or any other source will be held in the strictest confidence and will not be disclosed without your express and written permission.*

1. Name, address & telephone # of your physician \_\_\_\_\_

2. Date of last visit to your physician \_\_\_\_\_ Purpose of visit \_\_\_\_\_

3. Do you suffer from any disability? \_\_\_\_\_ If yes, describe \_\_\_\_\_

4. Are you taking any drugs or medications? \_\_\_\_\_ If yes, list and describe amounts and purpose. \_\_\_\_\_

5. Have you ever had an allergic reaction to medication? \_\_\_\_\_ If yes, describe. \_\_\_\_\_

*Note: There are many drug and medication incompatibilities, some of which may result in dangerous health problems. Information about your current use of drugs and medication is essential.*

6. Do you now have or have you ever had hepatitis? \_\_\_\_\_ If yes, describe \_\_\_\_\_

7. Do you have AIDS or are you HIV-positive? \_\_\_\_\_ If yes, describe and provide current status. \_\_\_\_\_

8. Do you now have or have you ever had a venereal disease? \_\_\_\_\_ If yes, describe. \_\_\_\_\_

9. Have you lost weight recently? \_\_\_\_\_ If yes, describe \_\_\_\_\_

10. Have you ever taken Phen/Fen or Redux? \_\_\_\_\_

11. For females: Are you pregnant? \_\_\_\_\_ If yes, when are you due? \_\_\_\_\_

12. For females: Are you taking birth control pills? \_\_\_\_\_ *Note: There are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills.*

13. Have you ever or do you now take illegal drugs? \_\_\_\_\_ If yes, what drugs and when taken?

*Note: There are drugs and medication used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal.*

Have You Ever Had Or Been Treated For:

14. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease? \_\_\_\_\_
15. Heart trouble, heart attack, angina, heart surgery, a pacemaker or irregular beats? \_\_\_\_\_
16. Abnormal blood pressure, excessive bleeding or anemia? \_\_\_\_\_
17. Stomach or intestinal disease? \_\_\_\_\_
18. Kidney problems or renal dialysis? \_\_\_\_\_
19. Breathing problems, asthma, tuberculosis or hay fever? \_\_\_\_\_
20. Cancer, X-ray treatments or chemotherapy? \_\_\_\_\_
21. Tumors or growths? \_\_\_\_\_
22. Diabetes? \_\_\_\_\_
23. A stroke, convulsions or fainting spells? \_\_\_\_\_
24. Arthritis or rheumatism? \_\_\_\_\_
25. Have you ever had a major operation? If yes, describe. \_\_\_\_\_
26. Have you ever had a serious injury to your head or neck? If yes, describe. \_\_\_\_\_
27. Do you smoke? If yes, describe type and quantity. \_\_\_\_\_
28. Are you on a special diet? If yes, for what reason and describe. \_\_\_\_\_
29. Have you consulted or been treated by a psychiatrist, psychologist or counselor? If yes, describe. \_\_\_\_\_
30. Are there any other problems about your health of which you are aware? \_\_\_\_\_

#### DENTAL HISTORY

Date of your last visit to a dentist \_\_\_\_\_  
Reason for your last visit (or series of visits) \_\_\_\_\_  
Do you have any of your X-rays or dental records? \_\_\_\_\_  
Name of previous dentist \_\_\_\_\_

In respect to any previous dental treatment, have you:

31. Ever fainted? \_\_\_\_\_
32. Had an allergic reaction? \_\_\_\_\_
33. Had abnormal bleeding? \_\_\_\_\_
34. Been told by a physician to premedicate prior to dental treatment? \_\_\_\_\_
35. Any other complication during or following dental treatment? \_\_\_\_\_

NOTE: A change in your health status should be reported to the office at the earliest possible time.

To the best of my knowledge, the foregoing questions have been accurately answered.

#### Permission To Release Health Information

I grant the right to the dentist to release health information obtained from me and information about my dental treatment to third party payers and/or other health practitioners.

Signature \_\_\_\_\_ Date \_\_\_\_\_