PATIENT REGISTRATION

NAME _____ HOME PHONE _____ CELL_____

ADDRESS _____ ZIP CODE _____

DATE OF BIRTH _____ SEX M F SINGLE MARRIED DIVORCED WIDOWED

SOCIAL SECURITY # _____ OCCUPATION _____

EMPLOYER _____ WORK PHONE _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____RELATIONSHIP TO PATIENT _____

DENTAL INSURANCE _____ GROUP # _____ INS. ID #_____

SPOUSE'S INFORMATION NAME _____ DOB _____ SOCIAL SECURITY # _____

EMPLOYER NAME AND ADDRESS _____WORK PHONE _____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

MEDICAL HISTORY PHYSICIAN'S NAME _____ PHONE _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE)

Heart Disease
Heart Attack
Heart surgery
Pacemaker
Artificial Heart Valve
Mitral Valve Prolapse
Rheumatic Fever
Scarlet Fever
High blood pressure
Angina
Artificial Joint

Cancer
Chemotherapy
Thyroid Disease
Excessive Bleeding
TB-Tuberculosis
Sinus Trouble
Aids/HIV
Venereal Disease
Psychiatric Treatment
Hemophilia
Stroke

Radiation Treatment
Diabetes
Arthritis/Rheumatism
Asthma
Emphysema
Glaucoma
Hepatitis A
Hepatitis B or ____
Chemical Dependency
Epilepsy/Seizures
Circulatory Problems

DO YOU HAVE OR HAVE YOU HAD ANY CONDITION NOT LISTED ABOVE? IF SO, PLEASE LIST:

_____

ARE YOU ALLERGIC OR HAVE YOU HAD AN ADVERSE REACTION TO ANY MEDICATION OR TO LATEX? IF SO, PLEASE LIST:

_____

ARE YOU TAKING ANY MEDICATIONS? IF SO, PLEASE LIST: _____

_____

HAVE YOU BEEN HOSPITALIZED IN THE LAST 2 YEARS? IF SO, WHY _____

DO YOU SMOKE? YES NO ALCOHOL USE: YES NO ARE YOU HAPPY WITH YOUR SMILE? YES NO

WOMEN: DO YOU SUSPECT YOU MAY BE PREGNANT? YES NO
ARE YOU ON BIRTH CONTROL PILLS? YES NO

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance. I will not hold the dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I will notify the office of any changes that may occur in the future.

Date: _____ Signature: _____

Witness Signature: _____

UPDATES: I CERTIFY THAT THERE HAVE BEEN NO CHANGES IN THE ABOVE INFORMATION.

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____