

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

## CERTIFICATION

To the best of my knowledge, the information provided on this form is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

## MINOR/CHILD CONSENT

I am the parent, guardian, or personal representative of \_\_\_\_\_  
Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

## INSURANCE ASSIGNMENT AND RELEASE

I certify that my dependent(s) is covered by insurance with \_\_\_\_\_  
Name of Insurance Company(ies)

and assign directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

## FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

\_\_\_\_\_  
Signature of Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient

## MEDICAL HISTORY UPDATE

Has there been any change in the patient's health since the last dental appointment?  Yes  No

For what conditions? \_\_\_\_\_

Is the patient taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dentist Signature

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\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dentist Signature