Referred by: _____

Patient Registration

Medical Alert:

Name:

Last **First** **Middle** **Nickname** **Date of Birth** **Gender M/F**

Address: **City:** **State:** **Zip:**

Home Phone:	Dental Insurance:
Cell phone:	Policy Holder:
E-mail:	Policy Holder Date of Birth:
Occupation:	Group:
Employer:	Soc. Sec. No:
Physician:	Secondary Insurance:
Phone:	Policy Holder:
In Case of Emergency Contact:	Policy Holder Date of Birth:
Phone:	Soc. Sec. No:

Patient Medical History

Do you or have you had any of the following? *(check all that apply)*

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Respiratory Disease
- ☐ Diabetes
- ☐ Cancer
- ☐ Rheumatic Fever
- ☐ Rheumatism or Arthritis
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Heart Murmur
- ☐ Blood Disease
- ☐ Stomach or Intestinal Disease
- ☐ Venereal Disease
- ☐ Yellow Jaundice
- ☐ Hepatitis A, B, or C
- ☐ Epilepsy
- ☐ AIDS/HIV Positive
- ☐ Tumors or Growths
- ☐ Mitral Valve Prolapse

CHECK YES OR NO

☐YES☐NO Are you allergic to any medicines including penicillin and aspirin?

☐YES☐NO Are you allergic to Latex?

☐YES☐NO Do you smoke or chew tobacco?

☐YES☐NO Women: Are you pregnant?

☐YES☐NO Are you under any medical treatment now?

☐YES☐NO Have you received any donor organs, artificial heart valves, vessels, joint implants or use a pacemaker?

☐YES☐NO Have you had any major operations? If yes, what?

_____

☐YES☐NO Are you currently taking drugs or medications? If yes, please list below.

Patient Dental History

☐YES☐NO Do you have any specific problems?

☐YES☐NO Do you have any unhealed injuries or inflamed areas in or around your mouth?

☐YES☐NO Any part of your mouth sore to pressures or irritants (cold, sweets, etc.)

☐YES☐NO Have you ever had local anesthetic?

☐YES☐NO Any reactions or allergic symptoms to local anesthetic?

☐YES☐NO Any difficult extractions in the past?

When was your last dental cleaning and or exam? _____

When was your last full mouth X-Ray taken? _____

Where? _____

If you answered YES to any of the questions please explain:

_____

_____

_____

Certification: *I certify that the answers given are correct to the best of my knowledge.*

Signature: _____

Date: _____

Recertification: I certify that there have been no changes in my health except as noted below.

Current Medication(s):	**Reason:**	**Date:**	**Change:**	**Signature:**