Registration Form and Medical History

PERSONAL INFORMATION

PATIENT'S LAST NAME | FIRST | INT.

HOME ADDRESS

STREET | CITY/STATE/ZIP

PHONE | CELL PHONE | PAGER

EMAIL ADDRESS

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME

RELATIONSHIP | PHONE

WORK INFORMATION

EMPLOYER

BUSINESS ADDRESS | CITY/STATE/ZIP

PHONE | CELL PHONE | PAGER

EMAIL ADDRESS

DENTAL INSURANCE INFORMATION

EMPLOYER NAME

EMPLOYEE NAME | DATE OF BIRTH

INSURANCE COMPANY | POLICY NUMBER

EMPLOYEE SOCIAL SECURITY NUMBER

MEDICAL HISTORY

1. Has your medical history changed within the last 2 years? ☐ Yes ☐ No
   If Yes, for what? _____

PHYSICIAN NAME | PHONE

ADDRESS

2. List any medications you are currently taking or have taken in the past two years _____

3. Circle any of the following that you are allergic to or have had reactions to:
   Local anesthetics like Novocaine Penicillin or other antibiotics — Aspirin Sulfa Drugs Iodine Latex
   Other _____

Circle any of the following you have had or have currently

Abnormal Bleeding
AIDS/HIV
Allergies/Hives or Skin Rash
Anemia
Arthritis or Rheumatism
Artificial Heart Valve
Artificial Joints or implants
Asthma or Hay Fever
Blood Transfusion
Bruise Easily
Chemotherapy
Cold Sores
Congenital Heart Lesions
Cortisone Medicine
Diabetes or Hypoglycemia
Drug Addiction
Emphysema
Epilepsy or Seizures
Fainting or Dizzy Spells
Genital Herpes
Glaucoma
Heart defect or heart murmur
Heart Disease/Heart Attack/ Angina
Heart Surgery
Hemophilia
Hepatitis A (Infectious)
Hepatitis B (Serum)
High Blood Pressure
Kidney Trouble
Liver Disease or Jaundice
Low Blood Pressure
Mitral Valve Prolapse
Nervousness
Pacemaker
Persistent cough
Psychiatric Treatment
Rheumatic Heart disease or fever
Sexually Transmitted Disease
Sickle Cell Disease
Sinus Trouble
Stroke
Thyroid Problems
Tuberculosis
Ulcers
Valvular Heart Infection
X-Ray/Cobalt Treatment

Do you have any problem, disease or condition NOT listed above? _____

Date of last physical examination _____

RELEASE

I authorize the dentist to perform diagnostic procedures and treatments as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advise, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I acknowledge that I am responsible for all costs of dental treatment. I attest to the accuracy of the above information.

I understand I will be charged for any missed or failed appointments without 48 hours prior notice. Charges will vary according to length of appointment time scheduled.

SIGNATURE | DATE | REVIEWED AND VERIFIED BY STAFF | DATE

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