PATIENT REGISTRATION AND MEDICAL HISTORY

Date:____/_____/____ Age:_____ Date of Birth:____/_____/____
Home Phone:_____ Cell Phone: _____ Work Phone: _____
Patient Name: _____ Social Security Number: _____
Patient Address: _____ E-Mail Address: _____
Town: _____ State: _____ Zip Code: _____
☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Employed by: _____
Business Address:_____ Occupation:_____
Name of Insurance Co.: _____ Group #:_____
Insurance Co. Address: _____ Insurance Co. Telephone #_____
Who is responsible for this account?_____
Whom may we thank for referring you?_____
Physician's Name: _____ Date of Last Physical: _____/_____/_____

Have you ever had any of the following? (Check boxes that apply):

☐ Heart Problems	☐ Epilepsy	☐ Special Diet
☐ High Blood Pressure	☐ Headaches	☐ Swollen Neck Glands
☐ Low Blood Pressure	☐ Hepatitis	☐ Rheumatic Fever
☐ Circulatory Problems	☐ Cancer	☐ Sinus Problems
☐ Nervous Problems	☐ Psychiatric	☐ A.I.D.S.
☐ Radiation Treatment	☐ Stroke	☐ Chronic Diarrhea
☐ Ulcer	☐ Allergies	☐ Back Problems
☐ Diabetes	☐ Arthritis	☐ Venereal Disease
☐ Hemophilia	☐ Artificial Valves	☐ Chemical Dependency
☐ Blood Disease	☐ Respiratory Disease	☐ Joint Replacement
☐ Latex Sensitivity	☐ Allergies to Bananas, Avocados or Chestnuts	

Do you have any drug allergies or have you ever had an adverse reaction to any medication? ☐ 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, please list:_____
Are you under the care of a physician? ☐ Yes ☐ No
For what conditions? _____
(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No

The above information is accurate and complete to the best of my knowledge and is for the use of my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any error or omissions that I may have made in the completion of this form.
I am also responsible for any unpaid balance, plus my deductible not covered by my insurance co. I also agree that if I suspend or terminate my care & treatment, any fees for services rendered me will be immediately due & payable.

Date: _____/_____/_____ Signature: _____