Patient Registration

Thank you for choosing our office to assist you with your dental needs.
Please fill out the information below and don't forget to provide your signature at the end.

Patient's name _____ Date of Birth _____

Sex:_____

If minor, name of legal guardian_____

Home phone _____ Mobile phone _____ Work phone_____

Email address:_____

Mailing address _____ City _____State _____ Zip _____

Employer _____

Whom may we thank for referring you to our office? _____

INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your SS# : _____ or Member ID#_____

Dental Insurance Co._____ Group number_____ Claims Address_____

Covered by spouse's insurance? ❑ yes ❑ no Spouse's Name _____

Spouse's dental insurance company _____ Group number _____

Spouse's birthday _____ SS# or Member ID# _____

MEDICAL HEALTH HISTORY

Do you have, or have you had any of the following? (Please check any that apply)

- ❑ **Are you required to Pre-medicate before any dental treatment?**
- ❑ Blood Problems (Anemia)
- ❑ Blood transfusion
- ❑ Heart problems
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Heart Pacemaker
- ❑ Stroke
- ❑ Bone or joint problems
- ❑ Artificial joint or valves
- ❑ High or low blood pressure (circle one)
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis, jaundice or other liver disease
- ❑ Diabetes TYPE 1 or TYPE 2
- ❑ Epilepsy or Neurological disorders
- ❑ Thyroid problems
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Cancer/Tumor
- ❑ Abnormal bleeding after any surgery (heavy bleeder)
- ❑ Hayfever or sinus trouble
- ❑ Allergies
- ❑ Asthma

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners e.g. Coumadin)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin other diabetes drugs
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Natural supplements
- ❑ Other:_____

Women:

- ❑ Are your pregnant or plant to become pregnant
- ❑ Taking hormones or contraceptives

Do you smoke,vape or use tobacco? ❑ yes ❑no

Name of your primary medical physician:_____Phone number_____

Signature of patient (or parent) ____ Date ___________________________