Patient Registration

Date _____ Name _____Title_____

Name to be called_____ Employer or School_____

SS# _____Birthdate_____

Patient's Mailing Address_____

Phone #s-home_____cell_____work_____

Email Address_____ Spouse's Name_____

For Urgent messages, whom should we contact? _____
Relationship to patient?_____

We are now confirming by email and text messages. If this does not apply to you, please see someone at the front desk.

Is this patient covered by DENTAL insurance? Y/N
Insured Party Employer _____
If yes, please present the insurance card to our front office.
Is there a secondary DENTAL insurance? Y/N
Insured Party Employer _____
If yes, please present that card also.

Person Responsible for this account -_____

Birthdate _____ SS# _____ Is this person a patient here? Y/N
Address _____
Phone #s –home-_____cell_____ work_____
Employed by _____

Signature of person completing the above _____

Health Information

Name Of General Physician_____

1. **Circle any of the following which you have or have had:**

-Joint replacement	**-Cancer**
- Heart Trouble	**- Abnormal Bleeding**
- Congenital Heart Defects	**- Asthma**
- High Blood Pressure	**- Diabetes – *If yes, how often do you check your blood sugar?***
- Circulatory Problems	
- Anemia	**- Venereal Disease**
- Rheumatic Fever	**- HIV Positive/AIDS**
- Osteoporosis	**- Hepatitis or Jaundice**
-Psychiatric Treatment	**- Arthritis**
- Tuberculosis	**- Stroke**
- Epilepsy	**- Headaches**

2. **Are you taking any medication(s)? Y/N Please list:**

3. **Are you allergic to any medicines or drugs? Y/N Please list:**

4. **Are you taking aspirin or blood thinning medication? Y/N Please list:**
5. **Are you taking any performance enhancing drugs? Y/N Please list:**
6. **Are you taking any drugs illegally? Y/N Please list:**

7. Females only – Are you pregnant? Y/N Due date:
Are you taking any prescribed birth control?Y/N
8. Please describe any health information or current medical treatment?
9. Name and location of previous dentist-

_____

10. *Date of last dental visit-*

_____

11. Please list any complications encountered in past dental treatments.

Signature of person completing the above:

_____

_____