PATIENT REGISTRATION/HEALTH HISTORY

Welcome to Our Office……..

Name____ BIRTHDATE_________________________

Address____ Zipcode_________________________

Home Phone#_______________ Work# _________________ Cell #________________________

Occupation________________________ Social Security#_____________________________

Employer Name and Address____

Marital Status_________ Spouse's Name_______________________________________

Previous Dentist_____________________________ Location_____________________________

Referred by____

Do you have dental insurance in your name? ______Employer_____________________________

Insurance Company__________________Phone#______________________________________

Do you have dental insurance in your spouse's name?____________Employer_______________

Insurance Company____

Address____ Phone#_____________________________

Social Security#______________Birthdate _____________ Occupation_______________________

HEALTH HISTORY

Date of last dental visit___________ Date of last x-rays__________________________________

Are you currently under the care of a physician for other than routine health visits?___________

If so explain____

Physician's Name____________________Phone#____

DO YOU OR HAVE YOU EVER HAD: (Y-YES, N-NO)

Heart Ailment yes______ no______		Diabetes yes______ no_____
Rheumatic Fever yes_____ no______		Epilepsy yes______no______
Heart Murmur yes______no______		AIDS OR HIV + yes_____ no ____
Mitral Valve Prolapse yes____ no_____		Allergy to drugs________________
Respiratory Disease yes______ no_____		High/Low Pressure yes______ no_____
Nervous/Mental Problems yes_____ no____		Cancer yes_____no_______
Prosthetic Joint Replacement yes_____ no______		
General Allergies yes____no______		

Has your physician recommended that you take antibiotics prior to your dental procedures?____

Please explain any YES"answers____

List medications taken____

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WOMEN: Are you pregnant or is there any chance you are pregnant? Yes ______ No _________

List medications taking____

Do you take birth control pills? Yes ______ No ________________________________

Please explain any "YES"answers____

The above information is accurate and complete to the best of my knowledge. I authorize this office to release any information necessary to process insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage. If account needs to be forwarded for collection I will be responsible for collection fees. Please be advised of our firm policy of no less than 24 hours notice when canceling an appointment. There will be a charge for broken appointments.

Date__________________Signature____