

Medical History

PATIENT NAME: _____ BIRTH DATE: _____

MEDICAL QUESTIONS: Please check yes or no:

Are you under a physician's care now?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain: _____
Have you been hospitalized/had a major operation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain: _____
Have you ever had a head or neck injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain: _____
Are you on a special diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain: _____
Do you use any tobacco products?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, what kind/how often: _____
Do you use/have you used any controlled substances?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, what kind/how often: _____
Do you/have you ever taken Phen-Fen or Redux?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

MEDICATIONS: Please list any and ALL medications, dosages and reason for taking. Attach separate sheet if needed.

I currently take no medications: (check box)

1. _____ Reason: _____	6. _____ Reason: _____
2. _____ Reason: _____	7. _____ Reason: _____
3. _____ Reason: _____	8. _____ Reason: _____
4. _____ Reason: _____	9. _____ Reason: _____
5. _____ Reason: _____	10. _____ Reason: _____

ALLERGIES: Check if you are allergic to any of the following:

Aspirin Penicillin Codeine Metal Latex Local Anesthetics Other: _____

FOR WOMEN ONLY: Please check Yes or No

Are you pregnant/trying to get pregnant? Yes No Taking hormonal contraceptives? Yes No Nursing? Yes No

MEDICAL CONDITIONS: Please check if you have or have had any of the following:

<input type="checkbox"/> AIDS/HIV Positive <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis/Gout <input type="checkbox"/> Artificial Heart Valve <input type="checkbox"/> Artificial Joint <input type="checkbox"/> Asthma <input type="checkbox"/> Blood Disease <input type="checkbox"/> Blood Transfusion <input type="checkbox"/> Breathing Problem <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Cancer <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Chest Pains <input type="checkbox"/> Cold Sores <input type="checkbox"/> Congenital Heart Disorder <input type="checkbox"/> Convulsions <input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Diabetes <input type="checkbox"/> Drug Addiction <input type="checkbox"/> Easily Winded <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy/Seizures <input type="checkbox"/> Excessive Bleeding <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Fainting/Dizziness <input type="checkbox"/> Frequent Cough <input type="checkbox"/> Frequent Diarrhea <input type="checkbox"/> Frequent Headache <input type="checkbox"/> Glaucoma <input type="checkbox"/> Hay Fever <input type="checkbox"/> Heart Attack/Failure <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Heart Pace Maker <input type="checkbox"/> Heart Trouble/Disease <input type="checkbox"/> Hemophilia <input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Hepatitis B or C <input type="checkbox"/> Herpes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Hives or Rash <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Kidney Problems <input type="checkbox"/> Leukemia <input type="checkbox"/> Liver Disease <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Lung Disease <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Pain in Jaw Joint <input type="checkbox"/> Parathyroid Disease <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Radiation Treatments <input type="checkbox"/> Recent Weight Loss <input type="checkbox"/> Renal Dialysis <input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Rheumatism <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Shingles <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Sinus Trouble <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Stomach/Intestinal Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Swelling of Limbs <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Tumors or Growths <input type="checkbox"/> Ulcers <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Yellow Jaudice
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Have you ever had any serious condition not listed above? Yes No If yes, explain: _____

Any Additional Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. I also understand that it is my responsibility to inform the dental office of any changes in my medical status.

Patient or Guardian Signature: _____ Date: _____



Patient Registration

Patient Information:

First Name: _____ Last Name: _____ M.I. _____
Preferred Name, if different from above: _____
Address: _____ City/State/Zip: _____
Home PH: _____ Work PH: _____ Mobile PH: _____
Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
Birth Date: ____/____/____ Age: ____ SSN: ____-____-____ Drivers Lic: _____
Email: _____ I would like to receive correspondence via email.
Occupation: _____ Employment Status: Full Time Part Time Retired N/A
Student Status: Full Time Part Time

Responsible Party/Head of Household (if someone other than patient):

First Name: _____ Last Name: _____ M.I. _____
Address: _____ City/State/Zip: _____
Home PH: _____ Work PH: _____ Mobile PH: _____
Birth Date: ____/____/____ SSN: ____-____-____ Drivers Lic: _____

Primary Insurance Information:

Name of Insured: _____ Relationship to Patient: Self Spouse Child Other
Employer: _____
Insurance Company and Plan Name: _____
Insured SSN OR Insurance Member ID: _____ Insured Birth Date: ____/____/____
Insurance Group #: _____

Secondary Insurance Information:

Name of Insured: _____ Relationship to Patient: Spouse Child Other
Employer: _____
Insurance Company and Plan Name: _____
Insured SSN OR Insurance Member ID: _____ Insured Birth Date: ____/____/____
Insurance Group #: _____