

## Patient Registration

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
 Patient is:  Policy Holder  Responsible Party Preferred Name \_\_\_\_\_

### Responsible Party (if someone other than the patient)

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
 Address \_\_\_\_\_ Address 2 \_\_\_\_\_  
 City, State, ZIP Code \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number \_\_\_\_\_ Drivers License Number \_\_\_\_\_  
 Responsible Party is also a Policy Holder for Patient  
 Primary Insurance Policy Holder  
 Secondary Insurance Policy Holder

### Patient Information

Address \_\_\_\_\_ Address 2 \_\_\_\_\_  
 City, State, ZIP Code \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed  
 Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Social Security Number \_\_\_\_\_ Drivers License Number \_\_\_\_\_  
 Email \_\_\_\_\_  I would like to receive correspondence via email.

### Section 2

Employment Status:  Full Time  Part Time  Retired  
 Student Status:  Full Time  Part Time  
 Medicaid ID \_\_\_\_\_ Preferred Dentist \_\_\_\_\_  
 Employer ID \_\_\_\_\_ Preferred Pharmacy \_\_\_\_\_  
 Carrier ID \_\_\_\_\_ Preferred Hygenist \_\_\_\_\_

### Primary Insurance Information

Name of Insured _____	Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured Social Security Number _____	Insured Birth Date _____
Employer _____	Insurance Company _____
Address _____	Address _____
Address 2 _____	Address 2 _____
City, State, ZIP Code _____	City, State, ZIP Code _____
Rem. Benefits _____	Rem. Deductions _____

### Secondary Insurance Information

Name of Insured _____	Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured Social Security Number _____	Insured Birth Date _____
Employer _____	Insurance Company _____
Address _____	Address _____
Address 2 _____	Address 2 _____
City, State, ZIP Code _____	City, State, ZIP Code _____
Rem. Benefits _____	Rem. Deductions _____

**Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.**

- Are you under a physician's care now?  Yes  No If Yes: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If Yes: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If Yes: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If Yes: \_\_\_\_\_
- Do you take, or have you taken, Phен-Fen or Redux?  Yes  No If Yes: \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?  Yes  No If Yes: \_\_\_\_\_
- Are you on a special diet?  Yes  No If Yes: \_\_\_\_\_
- Do you use tobacco?  Yes  No If Yes: \_\_\_\_\_
- Women: Are you...  Pregnant/trying to get pregnant?  Nursing?  Taking oral contraceptives?
- Are you allergic to any of the following?  Aspirin  Penicillin  Codeine  Acrylic  Metal  
 Latex  Sulfa Drugs  Local Anesthetics  Other \_\_\_\_\_
- Do you use controlled substances?  Yes  No If Yes: \_\_\_\_\_

**Do you have, or have you had, any of the following?**

- |                           |  |                           |  |                       |  |                            |  |
|---------------------------|--|---------------------------|--|-----------------------|--|----------------------------|--|
| AIDS/HIV Positive         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis B or C      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alzheimer's Disease       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Drug Addiction            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatism                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anaphylaxis               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Easily Winded             | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shingles                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or Seizures      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hives or Rash         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Gout            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Bleeding        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypoglycemia          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Thirst          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Irregular Heartbeat   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Spina Bifida               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joint          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting Spells/Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach/Intestinal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Cough            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Leukemia              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Diarrhea         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling of Limbs          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Transfusion         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Headaches        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breathing Problems        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Genital Herpes            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Disease          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsilitis                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bruise Easily             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors or Growths          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack/Failure      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain in Jaw Joints    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pains               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parathyroid Disease   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cold Sores/Fever Blisters | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Pacemaker           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Yellow Jaundice            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Trouble/Disease     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatments  | <input type="checkbox"/> Yes <input type="checkbox"/> No |                            |  |
| Convulsions               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent Weight Loss    | <input type="checkbox"/> Yes <input type="checkbox"/> No |                            |  |
| Cortisone Medicine        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Renal Dialysis        | <input type="checkbox"/> Yes <input type="checkbox"/> No |                            |  |

Have you ever had any serious illness not listed?  Yes  No If Yes: \_\_\_\_\_

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 my patient's) health. It is my responsibility to inform the dental office of any changes in medical status.**

**Signature of Patient, Parent, or Guardian**