REGISTRATION AND MEDICAL HISTORY

DATE________________________

PATIENT'S NAME ____________________DATE OF BIRTH________________ HOME PHONE________________________

ADDRESS ____ BUS. PHONE ________________________

CITY, STATE, ZIP ____ SINGLE________________________

IF CHILD, PARENT'S NAME __________________________________ MARRIED ________________________

SS # ____________________OCCUPATION________________________ DIVORCED ________________________

PATIENT EMPLOYED BY ____

BUSINESS ADDRESS ____

IN CASE OF EMERGENCY WHOM SHOULD BE NOTIFIED ____

____ PHONE ________________________

DO YOU HAVE ANY INSURANCE THAT MAY COVER ANY PART OF OUR PROFESSIONAL SERVICES? YES________ NO ________

NAME OF PRIMARY ________________________________ NAME OF SECONDARY ________________________________

ADDRESS ________________________________ ADDRESS ________________________________

POLICY # ________________ GROUP #____________ POLICY # ________________ GROUP #____________

PATIENTS RELATIONSHIP TO INSURED: SELF____ SPOUSE____ PATIENTS RELATIONSHIP TO INSURED: SELF____ SPOUSE____

INSURED NAME ________________________________ INSURED NAME ________________________________

INSURED SS#________________ D.O.B.____________ INSURED SS#________________ D.O.B.____________

INSURED EMPLOYER ________________________________ INSURED EMPLOYER ________________________________

EMPLOYER'S ADDRESS ________________________________ EMPLOYER'S ADDRESS ________________________________

***PLEASE NOTE:* PATIENTS WITH INSURANCE THAT WILL ONLY REIMBURSE THE MEMBER, OR ANY PATIENT WHO RECEIVES INSURANCE CHECKS WILL HAVE 14 DAYS FROM THE DATE THEY RECEIVE AN INSURANCE CHECK TO FORWARD THE CHECK TO OUR OFFICE. IF CHECK IS NOT RECEIVED WITHIN 14 DAYS, THE PATIENT WILL BE BILLED FOR OUR PRIVATE FEES FOR THEIR VISIT. THANK YOU FOR YOUR COOPERATION.**

WHO IS RESPONSIBLE FOR THIS ACCOUNT? ____

WHOM MAY WE THANK FOR REFERRING YOU? ____

PHYSICIAN'S NAME ____ PHONE ________________________

ADDRESS ____

PLEASE CIRCLE

HEART PACEMAKER ________	NO	YES	PROLONGED BLEEDING ________	NO	YES
HEART DISEASE ________	NO	YES	BLOOD TRANSFUSION ________	NO	YES
HEART VALVE REPLACEMENT ________	NO	YES	AIDS ________	NO	YES
ANGINA ________	NO	YES	HEPATITIS ________	NO	YES
RHEUMATIC FEVER ________	NO	YES	DIABETES ________	NO	YES
HEART MURMUR ________	NO	YES	ULCERS ________	NO	YES
PROLAPSED MITRAL VALVE ________	NO	YES	HAY FEVER ________	NO	YES
ABNORMAL BLOOD PRESSURE ________	NO	YES	SINUS PROBLEMS ________	NO	YES
CONGENITAL HEART LESIONS-DEFECTS ________	NO	YES	PERSISTENT COUGH ________	NO	YES
STROKE ________	NO	YES	ASTHMA ________	NO	YES
EPILEPSY/SEIZURE DISORDER ________	NO	YES	EMPHYSEMA ________	NO	YES
JAUNDICE ________	NO	YES	ANEMIA ________	NO	YES
HIV POSITIVE ________	NO	YES	GLAUCOMA ________	NO	YES
GONORRHEA ________	NO	YES	KIDNEY DISEASE OR DIALYSIS ________	NO	YES
SYPHILLIS ________	NO	YES	ANY TRANSPLANTED ORGANS ________	NO	YES
HERPES ________	NO	YES	ANY COMMUNICABLE DISEASES ________	NO	YES
X-RAY OR CHEMOTHERAPY ________	NO	YES	PAIN IN JAW JOINTS ________	NO	YES
DO YOU SMOKE ________	NO	YES	PIN, ROD, OR ANY FOREIGN OBJECT		
DO YOU DRINK ALCOHOLIC BEVERAGES ________	NO	YES	IMPLANTED IN YOUR BODY ________	NO	YES
OFFENSIVE BREATH ________	NO	YES	ANYTHING NOT LISTED ________	NO	YES
DO YOU OR HAVE YOU TAKEN DRUGS ________	NO	YES	IF SO, LIST ________	NO	YES
ARE YOU ALLERGIC TO LATEX ________	NO	YES			
ARE YOU ALLERGIC TO ANY MEDICATION ________	NO	YES	IF SO, LIST ________		

ARE YOU ALLERGIC TO LOCAL DENTAL ANESTHETICS: (NOVOCAINE, XYLOCAINE, CARBOCAINE, ETC ________ NO YES

ARE YOU PRESENTLY TAKING ANY MEDICATION NO YES IF SO, LIST ________

ARE YOU PRESENTLY UNDER THE CARE OF A PHYSICIAN NO YES IF SO, LIST REASON ________

DO YOU NORMALLY TAKE LOCAL ANESTHETIC FOR ROUTINE DENTAL TREATMENT ________ NO YES

DO YOUR GUMS BLEED EASILY WHEN BRUSHING NO YES

WHEN DID YOU LAST HAVE FULL MOUTH X-RAYS ________

PURPOSE OF THIS APPOINTMENT ________

____

FOR WOMEN ONLY

ARE YOU PREGNANT ________ NO YES

ARE YOU NURSING ________ NO YES

ARE YOU TAKING BIRTH CONTROL PILLS ________ NO YES

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE AND ALL ANSWERS ARE CORRECT. IF I HAVE ANY CHANGE IN MY HEALTH OR MEDICATION, I WILL INFORM YOU IMMEDIATELY.

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SIGNATURE OF PATIENT OR GUARDIAN