
# Patient Registration Form

Patient's name _____ Date of Birth _____

Sex:_____

If minor, name of legal guardian_____

Home phone _____ Mobile phone _____ Work phone_____

Email address:_____

Mailing address _____ City _____State _____ Zip _____

Employer _____

Whom may we thank for referring you to our office? _____

**INSURANCE INFORMATION:** ❑ Not covered by dental insurance

Your SS# : _____ or Member ID#_____

Dental Insurance Co._____ Group number_____ Claims Address_____

Covered by spouse's insurance? ❑ yes ❑ no Spouse's Name _____

Spouse's dental insurance company _____ Group number _____

Spouse's birthday _____ SS# or Member ID# _____

## MEDICAL HEALTH HISTORY

**Do you have, or have you had any of the following? (Please check any that apply)**

- ❑ **Are you required to Pre-medicate before any dental treatment?**
- ❑ Blood Problems (Anemia)
- ❑ Blood transfusion
- ❑ Heart problems
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Heart Pacemaker
- ❑ Stroke
- ❑ Bone or joint problems
- ❑ Artificial joint or valves
- ❑ High or low blood pressure (circle one)
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis, jaundice or other liver disease
- ❑ Diabetes TYPE 1 or TYPE 2
- ❑ Epilepsy or Neurological disorders
- ❑ Thyroid problems
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Cancer/Tumor
- ❑ Abnormal bleeding after any surgery (heavy bleeder)
- ❑ Hayfever or sinus trouble
- ❑ Allergies
- ❑ Asthma

**Are you allergic to, or have you reacted adversely to any of the following?**

- ❑ Latex
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

**Are you taking any of the following?**

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners e.g. Coumadin)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin other diabetes drugs
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Natural supplements
- ❑ Other:_____

**Women**:

- ❑ Are your pregnant or plant to become pregnant
- ❑ Taking hormones or contraceptives

**Do you smoke,vape or use tobacco? ❑ yes ❑no**

Name of your primary medical physician:_____ Phone number_____

Signature of patient (or parent) _____ Date _____