PATIENT REGISTRATION & MEDICAL HISTORY

Date: ___________ **Home #**__________________________ **Cell #**__________________________

Name: ____
Last First Initial (Preferred Name)

Address: ____
City ST Zip

Sex: Male____ Female____ **Age:** ______ **Date of Birth:** ____/____/____ **SS#**_______-______-_______

In case of emergency, who should be notified? ________________________________ Phone#______________________

MEDICAL HISTORY

Do you have, or have you had any of the following? *Please check "Yes" or "No" for each individual condition.*

Condition	Yes/No		Condition	Yes/No	
ALCOHOLISM	YES___ NO___	____________________	HEPATITIS	YES___ NO___	____________________
ARTIFICIAL HEART VALVE	YES___ NO___	____________________	HIGH BLOOD PRESSURE	YES___ NO___	____________________
AIDS / HIV	YES___ NO___	____________________	IMPANT/SURGICAL SCREWS	YES___ NO___	____________________
ANEMIA	YES___ NO___	____________________	JAUNDICE	YES___ NO___	____________________
ANGINA	YES___ NO___	____________________	JOINT PROTHESIS	YES___ NO___	____________________
ARTHRITIS	YES___ NO___	____________________	KIDNEY DISEASE	YES___ NO___	____________________
ASTHMA	YES___ NO___	____________________	LATEX ALLERGY	YES___ NO___	____________________
BLEEDING PROBLEMS	YES___ NO___	____________________	LIVER PROBLEMS	YES___ NO___	____________________
CANCER	YES___ NO___	____________________	LOW BLOOD PRESSURE	YES___ NO___	____________________
CHEMO/RAD THERAPY	YES___ NO___	____________________	LUNG DISEASE	YES___ NO___	____________________
COSMETIC SURGERY	YES___ NO___	____________________	PACE MAKER	YES___ NO___	____________________
DIABETES	YES___ NO___	____________________	PHEN FEN	YES___ NO___	____________________
DIZZY SPELLS	YES___ NO___	____________________	PSYCHIATRIC CARE	YES___ NO___	____________________
DRUG ADDICTION	YES___ NO___	____________________	RECREATIONAL DRUGS	YES___ NO___	____________________
EMPHYSEMA	YES___ NO___	____________________	RHEUMATIC FEVER	YES___ NO___	____________________
EPILEPSY	YES___ NO___	____________________	SEXUALLY TRANS DISEASE	YES___ NO___	____________________
FAINTING	YES___ NO___	____________________	SINUS TROUBLE	YES___ NO___	____________________
GLAUCOMA	YES___ NO___	____________________	SMOKING TOBACCO	YES___ NO___	____________________
HEART ATTACK	YES___ NO___	____________________	STROKE	YES___ NO___	____________________
HEART SURGERY	YES___ NO___	____________________	THYROID PROBLEMS	YES___ NO___	____________________
HEART MURMUR	YES___ NO___	____________________	TUBERCULOSIS	YES___ NO___	____________________
HEART PROBLEMS	YES___ NO___	____________________			

Are you under a Doctor's care at this time? YES___ NO___ If yes, please specify Doctor's Name:______________________________

For what reason?______________________________ Doctor's Ph# ________________________________

Are you taking any medication at this time, including birth control? YES___ NO___ If yes, specify: ______________________________

Are there any other health problems of which we should be advised? Please specify: ____

[Female] Are you pregnant/nursing at this time? YES___ NO___ If yes, how many months along: ______________________________

Are you allergic to penicillin, codeine, local anesthetics, tranquilizers, or any other drugs or medicine? ______________________________

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to the performing of x-rays and oral examination.

Patient signature: ____ Date: ______________________
(or parent if patient is a minor)

Doctor signature: ____ Date: ______________________

RECALL REVIEW:

Patient signature: ______________________ Date: __________ Patient signature: ______________________ Date: ____________

Patient signature: ______________________ Date: __________ Patient signature: ______________________ Date: ____________

Patient signature: ______________________ Date: __________ Patient signature: ______________________ Date: ____________