

**Patient Registration**

Patient full name \_\_\_\_\_ Gender (circle) male female **DOB** / /  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ **Soc. Sec. #** - -  
Home Tel: \_\_\_\_\_ Work ph: \_\_\_\_\_ Cell ph: \_\_\_\_\_ Email: \_\_\_\_\_

Person responsible for payment: (circle) **Self Other** If other, Gender (circle) male female  
Relationship: \_\_\_\_\_ **DOB** / / **Soc. Sec. #** - - Driver's. lic. # \_\_\_\_\_

**Insurance (circle) yes no Co-Insurance yes no Denti-cal yes no Healthy family yes no**

Personal Physician \_\_\_\_\_ Last visit \_\_\_\_\_ City \_\_\_\_\_ Tel: \_\_\_\_\_

Have you stayed in a hospital during the last 5 years? Yes No Reason? \_\_\_\_\_

Is your health: (circle) **good average poor** Have you ever taken any diet pills such as Phen-fen? **Yes No**

**Please mark yes or no if you now have or have ever had any of the following conditions:**

	Yes	No		Yes	No		Yes	No
high blood pressure	___	___	artificial heart valve	___	___	anemia	___	___
high cholesterol	___	___	pacemaker	___	___	dizziness	___	___
heart disease	___	___	implanted defibrillator	___	___	fainting spells	___	___
stroke	___	___	prosthetic joint	___	___	epilepsy	___	___
heart attack	___	___	<b>(antibiotics needed)</b>	___	___	psychiatric care	___	___
chest pain (angina)	___	___	<b>prior to dental Tx)</b>	___	___	headaches	___	___
rheumatic fever	___	___	shortness of breath	___	___	arthritis	___	___
heart murmur (defects)	___	___	lung disease	___	___	osteoporosis	___	___
bruises easily	___	___	tuberculosis	___	___	thyroid disease	___	___
swollen ankles	___	___	asthma	___	___	bleeding problems	___	___
diabetes	___	___	emphysema	___	___	stomach (ulcers)	___	___
liver disease (hepatitis)	___	___	sinus problems	___	___	kidney disease	___	___
cancer	___	___	chemotherapy	___	___	radiation treatment	___	___
immunosuppression	___	___	<b>women only: Are you pregnant?</b>	<b>Yes</b>	<b>No</b>	<b>Birth Control</b>	<b>Yes</b>	<b>No</b>

**Are you allergic to any of the following? (circle if yes) aspirin codeine penicillin latex dental anesthetic**

**Are you allergic to any other medications or foods? Please list:** \_\_\_\_\_

**MEDICATIONS YOU ARE TAKING NOW:** \_\_\_\_\_

**Are you taking any medications for osteoporosis such as FOSAMAX, ALENDRONATE, ACTONEL? Yes No**

**Do you have any other medical conditions not listed above?** \_\_\_\_\_

**{emergency contact} \_\_\_\_\_ relationship \_\_\_\_\_ Tel: \_\_\_\_\_**

**I FULLY UNDERSTAND AND TRUTHFULLY COMPLETED THE ABOVE FORM**

**Patient's / Guardian's Signature \_\_\_\_\_ dated \_\_\_\_\_**

**Reviewed by Doctor \_\_\_\_\_ dated \_\_\_\_\_**