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Patient Registration Form

Patient Information-

First Name: ______________ Last Name: ______________ Middle Initial: ______

Address: ______________ City, State, Zip: ______________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

E-mail: ______________

Sex: ○ Male ○ Female Marital Status: ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed

Birth Date: ______________ Age: ______ Social Security Number: ______________

Referred by: ______________

Emergency Contact-

Name: ______________ Phone Number: ______________

Responsible Party (parent/guardian if patient is a minor)-

First Name: ______________ Last Name: ______________ Middle Initial: ______

Mailing Address: ______________ City, State, Zip: ______________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Sex: ○ Male ○ Female

Birth Date: ______________ Age: ______ Social Security Number: ______________

Primary Insurance Information-

Name of Policy Holder: ______________ Social Security Number: ______________ Date of Birth: ______

Relationship to Patient: ○ Self ○ Spouse ○ Parent ○ Other

Employer: ______________ Member ID: ______________ Group #: ______

Insurance Company: ______________

Address: ______________

City, State, Zip: ______________

Insurance Co. Phone #: ______________

***Is policy holder address different from patient address ○ Yes ○ No**

Secondary Insurance Information-

Name of Policy Holder: ______________ Social Security Number: ______________ Date of Birth: ______

Relationship to Patient: ○ Self ○ Spouse ○ Parent ○ Other

Employer: ______________ Member ID: ______________ Group #: ______

Insurance Company: ______________

Address: ______________

City, State, Zip: ______________

Insurance Co. Phone #: ______________

***Is policy holder address different from patient address ○ Yes ○ No**

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.

Allergies: Are you allergic to or have you had a reaction to any of the following:

○ Aspirin ○ Penicillin ○ Codeine ○ Latex ○ Sulfa Drugs

○ Local Anesthetic Acrylic Metal

Other (please list) ______________________________

Are you taking any medications, pills, or drugs?	○ Yes	○ No	If yes, please list ______________
Are you under a physician's care now?	○ Yes	○ No	If yes, why ______________
Have you had any surgeries?	○ Yes	○ No	If yes, what ______________
Do you use tobacco?	○ Yes	○ No	
Do you use controlled substances?	○ Yes	○ No	

Women: Are you………

○ Pregnant ○ Nursing ○ Taking birth control

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

Artificial Heart Valve	Yes	No
Artificial Joint	Yes	No
Blood Thinner	Yes	No
Heart Attack/Failure	Yes	No
When? ______________		
Heart Disease/Trouble	Yes	No
Heart Murmur	Yes	No
Heart Pacemaker	Yes	No
Mitral Valve Prolapse	Yes	No
AIDS/HIV Positive	Yes	No
ADD/ADHD	Yes	No
Alzheimer's Disease	Yes	No
Anaphylaxis	Yes	No
Anemia	Yes	No
Angina	Yes	No
Arthritis/Gout	Yes	No
Asthma	Yes	No
Autism/Spectrum	Yes	No
Bipolar Disorder	Yes	No
Blood Disease	Yes	No
Blood Transfusion	Yes	No
When? ______________		
Breathing Problems	Yes	No
Bruise Easily	Yes	No
Cancer	Yes	No
Chemo/Radiation	Yes	No
Chest Pains	Yes	No
Cold Sores/Blisters	Yes	No
Convulsions	Yes	No
Cortisone Medicine	Yes	No
Diabetes	Yes	No
Dizziness	Yes	No
Emphysema	Yes	No
Epilepsy/Seizures	Yes	No
Excessive Bleeding	Yes	No
Excessive Thirst	Yes	No
Fainting Spells	Yes	No
Frequent Cough	Yes	No
Frequent Headaches	Yes	No
Genital Herpes	Yes	No
Glaucoma	Yes	No
Hemophilia	Yes	No
Hepatitis	Yes	No
Type? ______________		
Herpes	Yes	No
High Blood Pressure	Yes	No
High Cholesterol	Yes	No
Hives/Rash	Yes	No
Hypoglycemia	Yes	No
Irregular Heartbeat	Yes	No
Intestinal Disease	Yes	No
Kidney Problems	Yes	No
Leukemia	Yes	No
Liver Disease	Yes	No
Low Blood Pressure	Yes	No
Lung Disease/COPD	Yes	No
Osteoporosis	Yes	No
Psychiatric Care	Yes	No
Recent Weight Loss	Yes	No
Renal Dialysis	Yes	No
Rheumatic Fever	Yes	No
Rheumatism	Yes	No
Shingles	Yes	No
Sickle Cell Disease	Yes	No
Sinus Trouble	Yes	No
Stomach Problems	Yes	No
Stroke	Yes	No
Tuberculosis	Yes	No
Thyroid Disease	Yes	No
Tumors/Growths	Yes	No
Ulcers	Yes	No

Do you have any condition not listed above? Yes No If yes, ______________________________

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form and/or providing updated health information.

Signature of Patient, Parent or Guardian: ______________________________ Date: ______________