

Registration

Mr. Mrs. Miss _____ Birthdate _____ Age _____ Soc. Sec. No. _____

Home address _____ City _____ State _____ Zip _____ Phone _____

Dental insurance _____ Group or Plan No. _____ Referred by _____

Person financially responsible _____ Relationship to you _____ Soc. Sec. No. _____

Spouse name _____ Birthdate _____ Employer _____ Soc. Sec. No. _____

Occupation _____ Employer _____ Phone _____

Person to contact in case of emergency _____ Phone _____

Medical History

Physician _____ Address _____ Phone _____

Are you in good health? _____ If no, explain _____

Do you have an existing illness? _____ If yes, explain _____

Have you been hospitalized in the past two years? _____ If yes, explain _____

Do you bleed excessively when cut? _____ Do you smoke? _____ If yes, how much? _____

Are you taking any medication, pills or drugs? _____ If yes, please list: _____

Do you now have, or have you had any of the following? (If yes, describe under remarks.)

	YES	NO		YES	NO
1. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	14. Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
2. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	15. Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
3. Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	16. Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
4. Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	17. Asthma	<input type="checkbox"/>	<input type="checkbox"/>
5. Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	18. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
6. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	19. AIDS or HIV positive	<input type="checkbox"/>	<input type="checkbox"/>
7. Stroke	<input type="checkbox"/>	<input type="checkbox"/>	20. Allergy to: (a) Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
8. Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	(b) Other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
9. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	(c) Local Anesthetics	<input type="checkbox"/>	<input type="checkbox"/>
10. Tumor History	<input type="checkbox"/>	<input type="checkbox"/>	(d) Other	<input type="checkbox"/>	<input type="checkbox"/>
11. VD	<input type="checkbox"/>	<input type="checkbox"/>	21. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
12. Nervous Disorders	<input type="checkbox"/>	<input type="checkbox"/>	22. Have you ever used Fen-Phen?	<input type="checkbox"/>	<input type="checkbox"/>
13. Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>			

Dental History

Do you have any present dental complaints? ☐ Yes ☐ No What? _____

When was your last full-mouth X-ray taken? _____ Where? _____

When was your last cleaning? _____ Where? _____

Have you ever been instructed in the prevention of decay? _____

Have you ever been instructed in caring for your gums? _____

Remarks

I consent to whatever dental procedures and anesthetics are necessary for the treatment of the above named patient.

I also agree to assume full financial responsibility for all treatment rendered.

Signature _____ Date _____