Welcome to The Magnificent Smile

Patient Registration

Patient Name: _____ Date: _____

Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Social Security Number: _____ Date of Birth: _____

Referred By: _____

Occupation

Occupation: _____ Employer: _____

Dental Insurance Company: _____ Policy Number: _____

Spousal Information

Name of Spouse: _____

Occupation: _____ Employer: _____

Social Security Number: _____ Date of Birth: _____

Dental Insurance Company: _____ Policy Number: _____

Emergency Contacts

Name of Physician: _____

Physician Phone Number: _____

In Case of Emergency Contact: _____

Emergency Contact Phone Number: _____

Medical History

	Yes	No
1) Have you ever been hospitalized, had a major operation or serious illness?	☐	☐

If yes, please describe: _____

2) Are you under a physician's care now?	☐	☐

If yes, for what? _____

3) Have you had any allergic reactions to any medications?	☐	☐

If so, what? _____

4) Are you taking any medications?	☐	☐

If so, which ones? _____

5) Have you had abnormal bleeding after an extraction?	☐	☐
6) Do you smoke or use tobacco products?	☐	☐

7) Have you ever had:

	Yes	No		Yes	No
High Blood Pressure	☐	☐	Hepatitis	☐	☐
Heart Bypass Surgery	☐	☐	Liver Disease	☐	☐
Rheumatic Fever	☐	☐	Venereal Disease	☐	☐
Heart Murmur	☐	☐	AIDS	☐	☐
Mitral Valve Prolapse	☐	☐	Kidney Disease	☐	☐
Angina	☐	☐	Tumors or Cancer	☐	☐
Stroke	☐	☐	Diabetes	☐	☐
Hemophilia	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Epilepsy	☐	☐
Intestinal Disease	☐	☐	Respiratory Disease	☐	☐

8) Women, are you pregnant?	☐	☐

When are you due? _____

9) Signature: _____ Date: _____

10) Medical History Updates:

_____
_____
_____
_____
_____
_____
_____
_____
_____
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