REGISTRATION

Date_____

Patient's Full Name_____ Birthdate_____

Home Address_____

City_____ Zip_____ Phone_____

Sex: ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If Married, Spouse's Name_____

If Patient is a Child, Parent's Name_____

(If patient is a child, parents's employment)

Employed By_____ Occupation_____

Business Address_____ Work Phone_____

Spouse Employed By_____ Occupation_____

Business Address_____ Work Phone_____

Person Responsible for Account_____

Do You Have Dental Insurance? Yes ☐ No ☐

Do You Have MN Health Care Programs? Yes ☐ No ☐

Referred By_____

Former Dentist_____

PATIENT HEALTH QUESTIONNAIRE

Physician's Name_____

1. Are you under a physician's care now?..... ☐ Yes ☐ No
2. Have you been under a physician's care in the past two years?..... ☐ Yes ☐ No
3. Have you been in the hospital during the past two years?..... ☐ Yes ☐ No
4. Do you use tobacco products?..... ☐ Yes ☐ No

Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Mark (X) if you have or have had any of the following:

☐ Anemia	☐ Cortisone Treatment	☐ Hemophilia	☐ Psychiatric Treament
☐ Arthritis	☐ Cough, Persistent	☐ Hepatitis	☐ Radiation Treatment
☐ Artificial Heart Valve	☐ Diabetes	☐ High Blood Pressure	☐ Respiratory Disease
☐ Asthma	☐ Epilepsy	☐ HIV/AIDS	☐ Rheumatic Fever
☐ Back Problems	☐ Fainting	☐ Jaw Pain	☐ Scarlet Fever
☐ Blood Disease	☐ Glaucoma	☐ Joint Replacement	☐ Stroke
☐ Cancer	☐ Headaches	☐ Kidney Disease	☐ Thyroid Problem
☐ Chemical Dependency	☐ Heart Murmur	☐ Liver Disease	☐ Tonsillitis
☐ Chemotherapy	☐ Heart Problems	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Circulatory Problems	☐ Heart Surgery	☐ Pacemaker	☐ Ulcer

(OVER)

5. Have you had any disease, condition, problem, or surgery not listed on the previous page that could affect your dental treatment? If so, please list them.

_____

MEDICATIONS:

List medications, pills or drugs you are currently taking: _____

_____

_____

ALLERGIES: Please Mark (X) if have any of the following:

☐ Aspirin ☐ Barbiturates (Sleeping Pills) ☐ Penicillin ☐ Sulfa ☐ Latex ☐ Metals

☐ Local Anesthetic ☐ Codeine ☐ Other: _____

_____

The above information is accurate and complete to the best knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____ Signature_____

Medical History Updates:

Date:_____ Are there changes to your health? Yes_____ No_____ If yes, list_____

_____Signature_____

Date:_____ Are there changes to your health? Yes_____ No_____ If yes, list_____

_____Signature_____

Date:_____ Are there changes to your health? Yes_____ No_____ If yes, list_____

_____Signature_____

Date:_____ Are there changes to your health? Yes_____ No_____ If yes, list_____

_____Signature_____

Date:_____ Are there changes to your health? Yes_____ No_____ If yes, list_____

_____Signature_____

Date:_____ Are there changes to your health? Yes_____ No_____ If yes, list_____

_____Signature_____

Date:_____ Are there change to your health? Yes_____ No_____ If yes, list_____

_____Signature_____

Date:_____ Are there changes to your health? Yes_____ No_____ If yes, list_____

_____Signature_____

Date:_____ Are there changes to your health? Yes_____ No_____ If yes, list_____

_____Signature_____

Date:_____ Are there changes to your health? Yes_____ No_____ If yes, list_____

_____Signature_____

Date:_____ Are there changes to your health? Yes_____ No_____ If yes, list_____

_____Signature_____