Date_____

Single_____
Widowed_____
Married_____
Divorced_____
Separated_____

Registration / History

Patient's Name_____ D.O.B._____

Spouse's Name_____ D.O.B._____

Street Address_____ Phone_____

City_____State_____ Zip_____ Alt. Phone_____

Email_____

Patient Employed by_____ Phone_____

Business Address_____

Spouse Employed by_____ Phone_____

Business Address_____

Driver's License Number_____

In case of emergency, who should be notified_____ Phone_____

Name of Dental Insurance_____

Ins. ID #_____Grp#_____Policy Holder_____

Additional Dental Insurance_____

Ins. ID #_____Grp#_____Policy Holder_____

How did you hear about us?_____

PLEASE COMPLETE REVERSE SIDE

Date of last MEDICAL examination _____ Current Age _____

For what _____

Have you been hospitalized in the last 5 years _____ if so, for what _____

_____

Do you have or have you had:	Yes	No
Artificial Joint		
(Hip, Knee, etc. Replacement)		
Cancer or Tumors.....		
Diabetes.....		
Epilepsy		
Hepatitis		
Rheumatic fever.....		
Heart murmur or MVP		
Abnormal heart condition.....		
Abnormal bleeding from a cut ..		
HIV / AIDS		
Abnormal Blood Pressure.....		

	Yes	No
Asthma		
Are you allergic to:		
Penicillin.....		
Local Anesthetic.....		
Medication or Drugs.....		
Latex.....		
Peanuts		
Women: Are you pregnant?		
Do you take Blood		
Thinning Medication?.....		
Do you use herbal or		
alternative medication?.....		

If allergic to medications or drugs, indicate which ones _____

Are you taking any medication now _____ Please List _____

_____

So we can serve you better, please list any disability you may have _____

_____

Other physical conditions of which we should be aware _____

_____

Name of your physician _____ Phone _____

Are you receiving care now _____ If so, nature of care _____

Are you now receiving other health care Yes ❑ No ❑

If so, nature of care	Name of doctor	Phone