Registration & Health History

Patient Name_____ Date_____
Last, First MI (Preferred Name)

Address_____

_____

Birth Date:____/____/_____ Marital status_____ Social Security #: _____

Phone (Home) :(_____) - _____-_____ (Work): (____)-_____-_____ Ext._____

Email Address_____ Spouse's Name: _____

Date of Last Dental Visit_____ Reason for Today's visit_____

Have you ever had any of the following? Please circle those that apply:

AIDS/HIV	BLOOD DISORDER		PACEMAKER
ALLERGIES	CANCER	HEAD INJURIES	PREGNANCY: DUE DATE:
CODEINE ALLERGY	DEPRESSION	HEART DISEASE	RADIATION TREATMENT
PENICILLIN ALLERGY	DIABETES	HEART MURMUR	RESPIRATORY PROBLEMS
LATEX ALLERGY	EATING DISORDER	HEPATITIS	RHEUMATIC FEVER
ANEMIA	DIGESTIVE DISORDER	HIGH BLOOD PRESSURE	SINUS PROBLEMS
ARTIFICIAL JOINTS	EPILEPSY	KIDNEY DISEASE	STROKE
ARTIFICIAL HEART VALVE	EXCESSIVE BLEEDING	LIVER DISEASE	TUBERCULOSIS
FAINTING	MENTAL ILLNESS	TUMORS	ULCERS
ASTHMA	GLAUCOMA	OSTEOPOROSIS	VENEREAL DISEASE
ARTHRITIS			

Other Allergies/Health Concerns: _____

Do you use any alcohol products, if so how much do you use per day? _____

Have you ever been treated for alcohol or substance abuse? _____

If you are taking any medication please list_____

_____

_____

Are you taking coumadin/warfarin or other blood thinner? YES NO

Are you taking medications for osteoporosis or cancer? i.e. Actonel, Fosamax, Boniva, Zometa, Aredia, Prolia, Atelvia Yes NO

- Have you ever had any complications following dental treatment? YES NO
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? YES NO
  If yes, please explain: _____
- Are you under the care of a physician? YES NO
  If yes please explain: _____
- Name of physician:_____Phone_____
- Do you have any health problems that need further clarification? YES NO
  If yes please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of Patient: _____ Date:_____
Whom may we thank for referring you to our practice?_____