

## **MEDICAL HISTORY**

have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering following questions.  Are you under a physician's care now? Yes No If yes, please explain:  Have you ever been hospitalized or had a major operation? Yes No If yes, please explain:  Have you ever had a serious head or neck injury? Yes No If yes, please explain:  Are you taking any medications, pills, or drugs? Yes No If yes, please explain:  Are you take, or have you taken, Phen-Fen or Redux? Yes No  Are you on a special diet? Yes No  Do you use tobacco? Yes No  Do you use tobacco? Yes No  Do you need to pre-medicate? Yes No If yes, please explain:  Women: Are you Pregnant/Trying to get pregnant? Yes No If yes, please explain:  Women: Are you Pregnant/Trying to get pregnant? Yes No If yes, please explain:  Women: Are you pregnant/Trying to get pregnant? Yes No If yes, please explain:  Women: Are you pregnant/Trying to get pregnant? Yes No If yes, please explain:  Women: Are you pregnant/Trying to get pregnant? Yes No If yes, please explain:  Women: Are you pregnant/Trying to get pregnant? Yes No If yes, please explain:  Women: Are you pregnant/Trying to get pregnant? Yes No If yes, please explain:  Women: Are you pregnant/Trying to get pregnant? Yes No If yes, please explain:  Women: Are you pregnant/Trying to get pregnant? Yes No If yes, please explain:  Women: Are you pregnant/Trying to get pregnant? Yes No If yes, please explain:  Women: Are you pregnant/Trying to get pregnant? Yes No If yes, please explain:  Women: Are you allergic to any of the following?  AlbSiHIV Positive Yes No Cordisone Medicine Yes No Hempshilia Yes No Renal Dialysis Yes No Page Yes No Page Yes No Renal Dialysis Yes No Page Yes No Page Yes No Renal Dialysis Yes No Page Yes No Pa	a, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the wing questions.  Are you under a physician's care now? Yes No If yes, please explain:  Have you ever been hospitalized or had a major operation? Yes No If yes, please explain:  Have you to ver had a serious head or neck injury? Yes No If yes, please explain:  Are you taking any medications, pills, or drugs? Yes No If yes, please explain:  Do you take, or have you taken, Phen-Fen or Redux? Yes No  Are you on a special diet? Yes No  Do you use controlled substances? Yes No  Do you use controlled substances? Yes No  Do you need to pre-medicate? Yes No If yes, please explain:  Men: Are you Pregnant/Trying to get pregnant? Yes No If yes, please explain:  Men: Are you Pregnant/Trying to get pregnant? Yes No If yes, please explain:  Men: Are you Pregnant/Trying to get pregnant? Yes No If yes, please explain:  Men: Are you Pregnant/Trying to get pregnant? Yes No If yes, please explain:  Men: Are you Pregnant/Trying to get pregnant? Yes No If yes, please explain:  Men: Are you Pregnant/Trying to get pregnant? Yes No If yes, please explain:  Men: Are you Pregnant/Trying to get pregnant? Yes No If yes, please explain:  Men: Are you Pregnant/Trying to get pregnant? Yes No If yes, please explain:  Men: Are you Are you had, any of the following?  Notice of the followi	Are you under a physician's care now? Yes No If yes, please explain:  Have you ever been hospitalized or had a major operation? Yes No If yes, please explain:  Have you ever had a serious head or neck injury? Yes No If yes, please explain:  Are you taking any medications, pills, or drugs? Yes No If yes, please explain:  Do you take, or have you taken, Phen-Fen or Redux? Yes No Do you use tobacco? Yes No Do you use tobacco? Yes No Do you use controlled substances? Yes No Do you use controlled substances? Yes No Do you need to pre-medicate? Yes No Taking oral contraceptives? Yes No No If yes, please explain:  Women: Are you Pregnant/Trying to get pregnant? Yes No If yes, please explain:  Women: Are you altergic to any of the following?  Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics  Other If yes, please explain:  Do you have, or have you had, any of the following?  AlbS/HIV Positive Yes No Cortisone Medicine Yes No Hepatitis A Yes No Renal Dialysis Yes Anaphyaxis Yes No Diabetes Yes No Hepatitis A Yes No Renal Dialysis Yes No Paramania Yes No Early Winded Yes No Hepatitis Bor C Yes No Renumatic Fever Yes Naphyaxis Yes No Emphysema Yes No Hepatitis Bor C Yes No Renumatic Fever Yes Naphyaxis Yes No Emphysema Yes No Hepatitis Bor C Yes No Scarlet Fever Yes Naphyaxis Yes No Emphysema Yes No Hip Blood Pressure Yes No Singles Yes No Frequent Diarrhea Yes No Hip Blood Pressure Yes No Single Yes No Hip Blood	have, or medication that ye following questions.  Are you Have you ever been hosp	ou ma					th, your mouth is a part o	f your e	ntire bo	ody. Health problems tha	at you ma	
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## **PATIENT REGISTRATION**

ID:	Chart ID:		
First Name:	Last N	lame:	Middle Initial:
Preferred Name:			
Patient is:   Responsible I	Party	□ Policy Holder	
Responsible Party: ( if sor	neone other than the p	atient)	
First Name:	Last N	Jame:	Middle Initial:
Address:	Addre	ss 2:	
City, State, Zip:			
Home Phone:	Work Phone:		Cell Phone:
Birth date:	Social Security #:	Driv	vers Lic#:
• Responsible Party is Police	cy Holder for Patient	o Primary Policy Holder	<ul> <li>Secondary Policy Holder</li> </ul>
Patient Information:			
Address:	Addre	ss 2:	
City, State, Zip:			
Home Phone:	Work Phone:		Cell Phone:
Sex: o Female o Male	Marital Status: ○ Ma	rried o Single o Divorce	ed o Separated o Widowed
Birth date:	Social Security #:	Driv	vers Lic#:
E-mail:		□ I would l	ike to receive email correspondences
Patient Information (secti	on 2):		
Employment Status:   Full	Time o Part Time	○ Self Employed ○ R	etired o Unemployed
Student Status: oFull Time	o Part Time		
Preferred Dentist:	Preferred Hys	gienist: Pref	ferred Pharmacy:
Referred By:			
Medicaid ID:			

## **Primary Insurance Information:**

Name of Insured:	Relationship to Insured: OSelf OSpouse OChild OOther
Employer ID:	Carrier ID:
Insured Social Security #:	Insured Birth date:
Employer:	Insurance Company:
Address:	Address:
Address 2:	Address 2:
City, State, Zip:	City, State, Zip:

## **Secondary Insurance Information:**

Name of Insured:	Relationship to Insured: oSelf oSpouse oChild oOther
Employer ID:	Carrier ID:
Insured Social Security #:	Insured Birth date:
Employer:	Insurance Company:
Address:	Address:
Address 2:	Address 2:
City, State, Zip:	City, State, Zip: