Registration

Mr. Mrs. Dr.
Miss Ms. **Date**

Home Address **Home Tel:**

City **State** **Zip Code** **Cell Ph:**

Soc. Sec. # **Date of Birth** **Age**

Employer **Occupation**

Address **Bus. Tel:**

Spouse's Name **Soc. Sec. #** **Date of Birth**

Person Responsible for Account **Relationship to patient**

Address **Phone:**

Referred by

Purpose of Visit

Dentist **Dentist's Address**

Dentist's Phone#

Physician **Physician's Address**

Physician's Phone#

Medical History

1. **Are you in good health? _____**
2. **Date of last physical exam _____**
3. **Are you now under a physician's care? _____**

   If so, please give reason for care _____

   _____
4. **Are you pregnant? _____**
5. **Are you taking any medication now?**

   _____
6. **Please check any illnesses you have or have had**

- **High blood pressure**
- **Kidney or liver**
- **Venereal disease**
- **Rheumatic fever**
- **HIV positive**
- **Stroke**
- **Allergies**
- **Hepatitis**
- **Ulcer**
- **Recovered alcoholic**
- **Tuberculosis**
- **Diabetes**
- **Epilepsy**
- **Seizures**
- **Sinus**
- **Arthritis**
- **Anemia**
- **Heart trouble**
- **Glaucoma**
- **Asthma**
- **Thyroid**
- **AIDS**
- **Other _____**

7. **Have you ever had trouble with prolonged bleeding after surgery? _____**
8. **Have you ever had any unusual reaction to an anesthetic or drug (like penicillin)? _____**

   _____
9. **Is there any other information that should be known**

   about your health?

   _____

   about previous dental visits?

   _____

_____

Signature