REGISTRATION FORM / MEDICAL HISTORY

Date_____

****Both sides of this form must be completed, using ink****

Patient's Dentist_____

Name_____ Name I prefer to be called:_____
Last First Middle

Address_____ Home Phone (_____)_____

City_____ State_____ Zip Code _____ Work Phone (_____)_____

Birth Date_____Sex: M F Social Security #_____Other Phone (_____)_____

Employer Name & Address_____ Occupation_____

Marital Status_____ Spouse name_____Spouse Employer_____

Person responsible for account (if other than patient)_____ Relationship to Patient_____

In case of emergency, name and phone number of person to contact_____

Dental Insurance Information:

	Primary Dental Insurance Carrier	Secondary Dental Insurance Carrier
Insurance Company Name	_____	_____
Insurance Company Address	_____	_____
Insured's Name / Relationship to Patient	_____/_____	_____/_____
Insured's Birth Date	_____	_____
Insured's Social Security Number	_____	_____
Name of Group Policyholder or Union	_____	_____
Group Policy # / Individual Policy #	_____/_____	_____/_____
Insured's Employer	_____	_____

Medical and Dental History Information:

Some of the following questions may not relate to you or your medical condition, in that event, please write "N/A" (not applicable) in the space provided. All questions must be answered. All information supplied to our office on this form, or from any discussion with the doctor or received from your physician or any other source, will be held in the strictest confidence, and will not be disclosed without your permission. Any change in your health status should be reported to our office at the earliest possible time.

1. Physician Name and Location_____Physician Phone Number_____

   Are you currently being treated by a physician?_____If yes, for what?_____

   _____

2. Date of last visit to your physician:_____Purpose of visit:_____
3. Are you taking any drugs or medications, including herbal and nonprescription medications?_____If so, list all medications, along with the condition you take them for:_____

   _____

   _____

   _____
4. Have you **ever** taken the appetite suppressant drugs fenfluramine (Pondimin) or dexphenfluramine (Redux), commonly known as fen-phen?_____
5. Have you **ever** taken (or been given intravenously) bisphosphonate medications (such as Fosamax (alendronate), Actonel (risedronate), Zometa (zoledronate), Aredia (pamidronate) or others) for osteoporosis, Paget's disease, or chemotherapy?_____
6. For females: Are you pregnant?_____Are you taking birth control pills?_____***Note:*** *There are medications used in routine dental care that may reduce the effectiveness of birth control pills.*

********************Please turn this form over and complete the other side********************

7. Please list all drugs or medications that you are allergic to:_____

_____

8. Have you ever had an unfavorable reaction during or following dental treatment?_____If yes, please describe:_____

_____

9. Have you ever been advised of the need to routinely take antibiotics before dental treatment (examples of conditions which may require this are artificial joints or artificial heart valves)?_____If so, for what condition or problem?_____

Have you ever had, been diagnosed with, or been treated for:

10. Infectious disease (hepatitis, venereal disease, AIDS, tested HIV positive, etc.)?_____If yes, describe: _____

_____

11. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular heart beats?_____If yes, describe:_____

12. High or low blood pressure, stroke, bleeding disorders, or anemia?_____If yes, describe:_____

_____

13. Rheumatic fever, rheumatic heart disease, heart murmur, prolapsed mitral valve, or congenital heart disease?_____If yes, describe:_____

14. Stomach, liver, intestinal, or kidney problems? Renal dialysis?_____If yes, describe:_____

_____

15. Breathing problems, asthma, tuberculosis, or hay fever?_____If yes, describe:_____

_____

16. Cancer, x-ray treatments, or chemotherapy?_____If yes, describe and give current status:_____

_____

17. Diabetes?_____If yes, do you take insulin for your diabetes?_____

18. Convulsions, epilepsy, or fainting spells?_____If yes, describe:_____

19 Arthritis, rheumatism, or prosthetic joint(s)?_____ If yes, describe:_____

20. Have you ever had a serious injury to the head or neck?_____If yes, describe:_____

21. Have you ever had a major operation?_____ If yes, describe:_____

22. Are there are any other problems with your health of which you are aware?_____If yes, describe:_____

_____

Acknowledgement of Medical History Form Completion and Permission to Release Health Information:

To the best of my knowledge, all of the foregoing questions have been accurately and completely answered. I grant the right to the dentist to release health information obtained from me, and information about my dental treatment, to third party payors, and / or other health practitioners involved in my care.

Person completing this form: Signature:_____ **Date:**_____

Print Name:_____

I**f person other than patient is completing form, indicate relationship:** _____

********************Please ensure both sides of this form have been completed*****************

For Dentist Use Only: Dentist's History Review and Significant Findings:_____

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