# *REGISTRATION AND HEALTH HISTORY* [redacted]

## *Patient Information* *(Confidential)*

Patient Home / Cell Phone Number _____

Name _____ Date _____

Soc. Sec. # _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

If Student, Name Of School/College _____ City _____ State _____ ❑ Full Time ❑ Part Time

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

## *Responsible Party*

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____

Employer _____ Work Phone _____ SSN # _____

Is this Person Currently a Patient in our Office? ❑ Yes ❑ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

❑ Cash ❑ Personal Check Credit Card ❑ Visa ❑ MasterCard ❑ I wish to discuss the office's payment policy.

**Referred By** _____

## *Insurance Information*

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

## *Medical History*

Physician's Name _____ Date of Last Physical Exam _____

Do you have or have you had any of the following. Please indicate with check mark ( ✓ ).

__ Any heart problems
__ High blood pressure
__ Low blood pressure
__ Circulatory problems
__ Nervous problems
__ Radiation treatments
__ Excessive bleeding
__ Aids
__ Allergies to anesthetics
__ Allergies to medicines
__ or drugs
__ Allergies to _____
__ Anemia
__ Arthritis
__ Asthma
__ Diabetes
__ Any blood thinners, Asprin, Plavix, Coumadin
__ Hepatitis
__ Herpes
__ Malignancies
__ Measles
__ Mumps
__ Psychiatric care
__ Rheumatic fever
__ Scarlet fever
__ Previous History of Endocarditis
__ Sinus problems
__ Stroke
__ Typhoid fever
__ Tonsillitis
__ Tuberculosis
__ Ulcer
__ Venereal disease
__ Joint replacement
__ Other

Are you pregnant _____ Blood Pressure: S____/D____/____

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment. **Please list all your current medications.**

_____

_____

_____

Date: _____ Your signature: _____