PATIENT REGISTRATION AND MEDICAL HISTORY

DATE:____/____/____.

Patient :_____.
Last name First Name Middle initial Preferred Name

Street Address :_____ City _____ State ____ Zip ____.

Email_____ Cell phone( ) - Home phone( ) .

Sex : Female Male AGE____ Birth date ___/___/____.

Employer/School Occupation_____.

Employer/School address_____ Employer/School phone ( ) - .

Spouse/Parent Name_____ Spouse/Parent Birth date_____.

Spouse/Parent Employed by Occupation_____.

Business Address _____ Business Phone ( ) - .

Social Security Number _____ Spouse/Parent's Social Security Number_____.

Who is responsible for this account? _____ Relationship to the Patient_____.

Name of Dental Insurance Company _____ Group number_____.

In case of emergency, who should be notified? _____ Phone ( ) - .

Whom may we thank for referring you?_____.

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____.

Have you ever had any of the following? (circle all that apply):

Allergies	Arthritis	Artificial Heart Valves or Joints, Screws, etc	Back Problems
Bleeding Abnormally	Blood Disease	Cancer	Chemical Dependency
Chronic Diarrhea	Circulatory Problems	Congenital Heart Lesions	Diabetes
Epilepsy	Headaches	Heart Murmur	Heart Problems
Hemophilia	Hepatitis, Jaundice or Liver Disease		Hernia Repair
High Blood Pressure	HIV/AIDS	Low Blood Pressure	Mitral Valve Prolapse
Nervous Problems	Pacemaker	Psychiatric Care	Radiation Treatment
Recent Weight Loss	Respiratory Disease	Rheumatic Fever	Sinus Problems
Special Diet	Stroke	Swollen Neck Glands Ulcer	Venereal Disease

Do you have any drug allergies or have you had an adverse reaction to any medication or anesthesia? Yes/No

If so, what? _____.

Have you ever responded adversely to medical or dental treatment? Yes/No

Are you taking any medication at this time? . If so, what?_____.

-OVER-

Have you ever taken any of the group of drugs collectively referred to as 'FEN-PHEN'? These include combination of Ionimin, Adipex, Fastin (Brand names of phentermine), Pondimin (Fenfluramine) and Redux (dexfenfluramine.) YES/ NO

Are you under the care of a physician? YES/NO For what conditions?_____.

If patient is a child, what is his/her weight? _____.

(Women) Do you suspect that you are pregnant? YES/NO Due date_____/_____.

Are you nursing? YES/NO Taking birth control pills? YES/NO

Is there anything else we should know about your medical history?_____.

CERTIFICATION

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION I HAVE PROVIDED ON THIS FORM IS COMPLETE AND CORRECT. I UNDERSTAND THAT REPORTING INCOMPLETE OR INACCURATE INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT I AM SOLELY RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM MY DOCTOR IF I , OR MY MINOR CHILD, EVER HAVE A CHANGE IN HEATLH.

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE :_____.
DATE :_____/_____/_____.

PRINT NAME OF PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE _____.

RELATIONSHIP TO PATIENT_____.