

PATIENT REGISTRATION

Today's Date: _____

Mr.
Mrs.
Miss
Patient's Name: _____ Male: _____ B-day _____ Home # _____
Female: _____ S.S.N. _____ Work # _____

Patient Employed By _____

Patient Home Address _____ City _____ State _____ Zip _____

If child, mother's name: _____, Employed by _____, Work # _____

If child, father's name; _____, Employed by _____, Work # _____

Do you have insurance that may cover part of our professional services? Yes or No

Policy Holder's Name: _____ S.S.N. _____ B-day _____

Employed by _____

Name of Primary Insurance Company: _____

ID # _____ Group # _____

Company's Billing Address: _____

Do you have Secondary Insurance Coverage? Yes or No

Policy Holder Name _____ S.S.N. _____ B-day _____

Employed By _____

Name of Secondary Insurance Company _____

_____ Group # _____

Company's Billing Address _____

★!Payment is expected when service is rendered unless other arrangements are made in advance.

Who will pay this account? _____ S.S.# _____ B-day _____

Billing Address _____ Telephone _____

Whom may we thank for referring you? _____

Signature _____

The Dental Health Group, LLP
Patient Identification and Medical/Dental History

Patient's Name _____ Nick Name _____
Parents/guardians (if minor) _____ Birth Date _____
Reason for visit _____
How long since you have last seen a dentist? _____

Medical History (please check if you have ever had any of the following):

Heart trouble _____	Diabetes(I or II) _____	Anemia _____
Heart defects _____	Tuberculosis _____	Asthma _____
Artificial Joint Replacement _____	Stroke _____	Sinusitis/allergies _____
Cardiac Pacemaker _____	Psych tmt _____	Epilepsy _____
High Blood Pressure _____	Asthma _____	Chest pain/angina _____
HIV/AIDS _____	Venereal Disease _____	Other _____
Hepatitis/type _____	Emphysema _____	_____

Are you now pregnant? Y N # Weeks _____
Do you use tobacco or alcohol? List amount/frequency/yrs of use _____

Do you or have you ever had cancer, chemotherapy, or radiation treatment? Explain type and treatment: _____

Do you have a blood/clotting disorder? _____

Have you ever taken bisphosphonates (Fosamax, Actonel, Boniva, etc) for osteoporosis or cancer treatment? _____

Please list any other information you feel we should know about _____

List current medications/drugs including over the counter supplements: _____

List any other medications/drugs you have taken in the past 2 years: _____

Explain any hospitalizations within the last 3 years: _____

Are you allergic to any medications? List: _____

Dental History (please check if you have had undesirable reactions from any of the following):

Oral Surgery _____	Tooth Extraction _____
Lidocaine/anesthetics _____	Penicillin/antibiotics _____
Jewelry or metals _____	Other _____

Do you wear dentures or partials? _____

What are your main dental concerns? _____

Name of Physician(s) _____ Purpose/date last visit _____

Patient/Guardian's signature _____