Welcome! So that we may provide you with the best possible care, please complete **both** sides of this medical/dental history form.

Medical Alert

PATIENT REGISTRATION AND MEDICAL HISTORY

Date___________________

Home # __________________ Work # _____________________ **Cell #** ______________________ **Preferred contact #** __________________

Patient____ ______________________
Last Name **First Name** **Initial** **Preferred Name**

Social Security # __________________________________ E-mail Address ___________________________@_________________

Street Address _______________________________________ City_______________________ State________ Zip____________________

Sex: M F Age_________ Birthdate________________ Single Married Widowed Separated Divorced

Employed by____ Occupation____

Business Address____ Business Phone __________________________

Spouse Name ____ Spouse SSN# __________________________

Spouse Employed by ____ Occupation ____

Business Address____ Business Phone __________________________

Who is responsible for this account? ______________________________________ Relationship to Patient___________________________

Responsible Party's SSN # ___________________ Employer _______________________________ Employer's Phone______________________

WHOM MAY WE THANK FOR REFERRING YOU? ____

Dental Insurance Primary Carrier

Insured's Name _______________________________________

Insurance Co. ____

Ins. Co. Address _____________________________________

____

Insured's Employer ___________________________________

Insured's SSN # ______________________________________

Insured"s Birthdate ___________________________________

Group # ____________ I.D. #___________________________

Dental Insurance Secondary Carrier

Insured's Name ____

Insurance Co. ____

Ins. Co. Address ____

____

Insured's Employer ____

Insured's SSN # ____

Insured"s Birthdate ____

Group # _______________ I.D. #__________________________________

In case of emergency, who should be notified?____ Phone __________________________________

Do you have any drug allergies or have you ever had an adverse reaction to any medication? **YES** **NO** If so, what? ___________________________
____

Has a physician ever told you to "pre-medicate" for dental treatment? **YES** **NO**

Have you ever had any of the following? **YES** **NO** If YES, please circle those that apply.

A.I.D.S." / HIV Disease	Chronic Diarrhea	Hepatitis A	Recent Weight loss	❖ Artificial Heart Valves
Allergies to Anesthetics	Chronic Headaches	Hepatitis B	Respiratory Disease	❖ Artificial Joints
Allergies to Latex	Circulatory Problems	Hepatitis C	Rheumatic Fever	❖ Heart Murmur
Allergies to Medications/ Drugs	Diabetes	Hepatitis Type _____	Sinus problems	❖ Mitral Valve Prolapse
Allergies to Colored Dyes	Epilepsy/Seizures	Hypoglycemia	Special diet	❖ Stint
Angina Pectoris	General Allergies	High blood pressure	Swollen neck glands	❖ Shunt
Arthritis	Glaucoma	Low blood pressure	Stroke	
Back problems	Heart Disease	Jaundice, or Liver Disease	Thyroid Disease	
Blood Disease	Heart Pacemaker	Kidney trouble	Tuberculosis	
Cancer, Leukemia	Hemophilia/Excessive Bleeding	Nervous problems	Ulcer	
Chemical Dependency	Psychiatric care	Radiation treatment	Venereal Disease: Type______________	

Physician's Name ____ Date of Last Physical _______________________