REGISTRATION/ MEDICAL DENTAL HISTORY FORM

Date _______________

PLEASE PRINT

Patient Name ______________________

Address___________________________

City ___________ State_____ Zip_______

Home Telephone # ___________________

Cell phone #_________________________

Email ______________________________

Birth Date ____________ Sex __________

☐ Single ☐ Married ☐ Widowed ☐ Other

Your Occupation _____________________

Work Phone # _______________________

Employed by _________________________

Employer's address_____________________

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Whom may we contact in case of an emergency? __________________________

Emergency contact phone # ______________

SS# ____________________________

Name of Spouse/Parent ________________

Spouse/Parent's Occupation _____________

Work Phone # ________________________

Employed by _________________________

Employer's address ___________________

Have you been a patient in this office before? __________________________

Referring Dentist ____________________

Physician ___________________________

Pharmacy ___________________________

____

Patient Name ________________________ Date ___________

Allergies to:
Latex: Yes No
Medications ______________________
Other___________________________

PreMed required? Yes No
Reason _______________
Type _____________ Dosage __________

Have you ever had a reaction to dental anesthesia (e.g., lidocaine) or nitrous oxide? Yes No

Current Medications (Prescription, over the counter, and herbal)

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

PAST AND CURRENT MEDICAL CONDITIONS (Check YES for all that apply)

Under physician's care Details:		Hospitalization/operation(s) in the last 5 years Details:	
Asthma		Sleep Apnea	
History of Bisphosphonate use?		Tuberculosis	
Head/ neck/ mouth injuries		Sinus trouble	
Women: Pregnant		Cancer	
Women: Nursing		Radiation treatment to Head/Neck	
Women: Oral contraceptives		Chemotherapy	
Heart trouble/disease		Kidney Disease	
Rheumatic fever		Dialysis	
Past use of Fenphen		Eating Disorder	
Heart murmur		Stomach: Reflux __ Ulcer__	
Mitral valve prolapse		Immunological disease	
Heart surgery		Sjogrens Disease	
Artificial heart valves		Fibromyalgia	
Pacemaker		Other autoimmune disease (Lupus, Pemphigus)	
Indwelling defibrillator		Arthritis or other joint disorders	
Artificial joints		Diabetes: Type: Controlled: Y/N	
History of Organ Transplant		Headaches	
High blood pressure BP: /		Depression: Diagnosed	
Stroke		Other Psychiatric Disorders	
Bleeding problem		Neurologic Disease	
Hemophilia		Convulsions	
Anemia		Epilepsy/ seizures	
Leukemia		Cerebral Palsy	
Lung Disease		Fainting/ Dizziness	
Emphysema		Venereal Disease	
Shortness of Breath		AIDS/ HIV positive	
Glaucoma		Alcohol or chemical dependency	
Thyroid Disease		Hepatitis	

Patient Signature ____________________________ Date ___________________