Patient Registration and Medical History

Name (Last, First, Middle Initial) _____

Preferred name _____ Home Phone _____ Cell Phone _____

Physician's Name _____ Presently under physician's care? _____YES _____ NO

If yes, please explain. _____

Do you smoke? _____YES _____ NO Do you use smokeless chewing tobacco? _____ YES _____ NO

Have you ever had any of the following? (Please check YES or NO)

	YES	NO		YES	NO
Rheumatic fever	☐	☐	High blood pressure	☐	☐
Heart defect	☐	☐	Blood thinner	☐	☐
Heart surgery	☐	☐	Hepatitis, Jaundice, or Liver disease	☐	☐
Stroke	☐	☐	Lung or breathing problems	☐	☐
Sinus trouble	☐	☐	Seizures	☐	☐
Fainting spells	☐	☐	Aids or HIV infection	☐	☐
Diabetes	☐	☐	Arthritis	☐	☐
Thyroid problems	☐	☐	Tuberculosis	☐	☐
Joint replacement	☐	☐	Epilepsy	☐	☐
Cancer	☐	☐	Pregnancy	☐	☐
Anemia	☐	☐	Nervous problems or Psychotherapy	☐	☐
Heart Disease	☐	☐	Other	☐	☐
Heart Murmur	☐	☐	Please Specify _____		
Heart attack or Angina	☐	☐	_____		

Have you ever taken pre-medication prior to a dental appointment? _____ YES _____ NO
If yes, please explain. _____
Are you taking any medications at this time? _____ YES _____ NO If yes, please list. _____
_____

ARE YOU ALLERGIC OR HAVE YOU EVER REACTED ADVERSELY TO: (Circle yes or no)

	YES	NO	Explanation
Penicillin or other antibiotics	☐	☐	_____
Sulfa drugs	☐	☐	_____
Codeine or other narcotics	☐	☐	_____
Latex	☐	☐	_____
Other	☐	☐	_____

*The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____