ADULT REGISTRATION AND HEALTH HISTORY

Name _____ Nickname _____

SS# _____ Birthdate _____ Age _____

Sex M____ F____ Single _____ Married_____ Divorced_____

Separated_____ Widowed_____ Minor_____

Address _____ City_____ State_____ Zip _____

E-mail Address _____

Home Phone_____ Cell Phone_____ Work Phone _____

Employer_____ How Long Employed? _____

Spouse _____ Employer_____ SS# _____

Home Phone_____ Cell Phone_____ Work Phone_____ Birthdate_____

Do we have your permission to use your info to text and/or email a message to confirm or otherwise contact you? ☐ yes ☐ no

RESPONSIBLE PARTY:_____ Relationship to patient_____

Address _____

SS# _____ Birthdate _____

Home Phone_____ Cell Phone_____ Work Phone _____

Whom May We Thank For Referring You? _____

Who would we call in case of Emergency? _____

DENTAL INSURANCE INFORMATION

Name of Insured Person_____ Relationship to patient _____

Birthdate_____ ID# _____ Date Employed _____

Employer_____ Work Phone _____

Insurance Company_____ Group #_____

Annual Maximum Benefit?_____ Deductible _____

SECONDARY DENTAL INSURANCE INFORMATION

Name of Insured Person_____ Relationship to patient _____

Birthdate_____ ID# _____ Date Employed _____

Employer_____ Work Phone _____

Insurance Company _____

Annual Maximum Benefit?_____ Deductible _____

OVER ➢

DENTAL AND MEDICAL HISTORY

How long has it been since you have seen a dentist?_____

Medical Physician's Name_____ **Date of last Physical Exam** _____

Do you have or have you had any of the following. Please indicate with check mark (✔).

____Pacemaker	____Allergies to anesthetics	____Circulatory Problems	____Psychiatric Care
____Heart Murmur	____Allergies to Metal	____Stroke	____Rheumatic Fever
____Mitro Valve Prolapse	____**ALLERGIES TO MEDICINES OR DRUGS (list below)**	____Diabetes	____Seizures
____Stents (date_____)		____Hepatitis	____Sinus Problems
____Artificial Heart Valve	____Allergies to food, latex, animals,	____Herpes	____Thyroid
____Congenital Heart Problems	etc. (list below)	____HIV/AIDS	____Typhoid Fever
____History of Infective endocarditis	____Anemia	____High Blood Pressure	____Tuberculosis
____Surgical Heart Repair	____Arthritis	____Low Blood Pressure	____Ulcer
____Any heart problems	____Artificial Joints/Replacements	____Malignancies	____Venereal Disease
(list below)	____Asthma	____Radiation Treatments	____Other
	____Excessive Bleeding	____Nervous Problems	

Are you pregnant_____ Blood Pressure: S_____/D_____/_____

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment. PLEASE LIST MEDICATIONS, DOSAGE AND HOW TAKEN.

_____

_____

_____

_____

_____

PLEASE LIST ALL ALLERGIES, INCLUDING MEDICINE & FOODS:

_____

_____

The Hippa Privacy regulations have been made available to me. _____

Date_____ **Your Signature** _____

Date_____ **Your Signature** _____

Date_____ **Your Signature** _____

Date_____ **Your Signature** _____

Date_____ **Your Signature** _____

Date_____ **Your Signature** _____

Date_____ **Your Signature** _____

Date_____ **Your Signature** _____

Date_____ **Your Signature** _____

Date_____ **Your Signature** _____