



Patient Registration and Medical History



Date _____

PLEASE PRINT

Patient _____ Date of Birth _____ Sex M F

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____ Married Single Divorced
 Widowed Separated Minor

Emergency Contact Name _____ Phone _____

Other Family Members Seen Here _____ Whom may we thank for referring you? _____

School _____ Grade _____ School Phone _____

Employer _____ Occupation _____ Work Phone _____

Father's/Guardian Name Dr./Mr. _____

Address (if different from above) _____ City _____ State _____ Zip _____

Employer _____ Occupation _____ Work Phone _____

Mother's/Guardian Name Dr./Mrs./Ms. _____

Address (if different from above) _____ City _____ State _____ Zip _____

Employer _____ Occupation _____ Work Phone _____

Who is Responsible for this account? _____ Relationship to Patient _____

Medical and Dental History

Dentist's Name _____ Date of last dental cleaning and x-rays: _____ Physician's Name _____

Reason for consultation: _____

Has patient had an orthodontic evaluation in the last two years? Yes No

If yes, please specify: _____

Is medication required before dental procedures? Yes No

If yes, please specify: _____

Are you taking medication at this time? Yes No

If yes, please specify: _____

Do you have any drug allergies or have you ever had an adverse reaction to any medication? Yes No

If yes, please specify: _____

Are you under the care of a physician? Yes No

For what conditions?: _____

Is there anything else we should know about your medical history? Yes No

If yes, please specify: _____

Patient has a history of:

(PLEASE CHECK ALL THAT APPLY)

- Allergies
- Asthma
- Blood Disease
- Bone Disorder
- Diabetes
- Endocrine Problems
- Epilepsy
- Heart Disease
- Hepatitis
- High Blood Pressure
- Latex Allergy
- Learning Disability
- Rheumatic Fever
- Traumatic Injury

Other: _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I authorize the release of dental and medical records relevant to dental treatment, or copies of such, to communicate/coordinate treatment.

Signature

Date