REGISTRATION / HISTORY

Date _____

Patient's Name _____ _____ Single ___
Widowed ___
Name of Spouse _____ Married ___
Divorced ___
If a Child, Parent's Name _____ _____ Separated ___

Street Address _____ ____ _____ Phone _____

City _____ _____ State _____ Zip _____ ____

Patient Employed by _____ Phone _____

Business Address _____ _____

Present Position _____ How long held _____

Spouse Employed by _____ Phone _____ _

Business Address _____

Present Position _____ _____ How long held _____

Purpose of this appointment _____ _____

In case of Emergency, who should be notified _____ Phone _____

Who will pay this account _____

Social Security Number _____ Birthdate _____

Spouse's Social Security Number _____ Birthdate _____

If using charge card, Name _____ Card No. _____

If welfare, your number _____ _____ County of _____

Do you have insurance that may cover any part of our professional services . . . . . Yes _____ No _____

If so, name of primary company _____ _____ Policy No. _____

Is policy connected with your union Yes ___ No ___ If yes, name of union _____ _____

Local No. _____ _____ Group No. _____ _____

Social Security No. of Policy Holder _____ _____

Do you have any other insurance . . . . . Yes _____ No _____

If so, name of secondary company _____ ___ Policy No. _____

Is policy connected with a union Yes ___ No ___ If yes, name of union _____ ____ _____

Local No. _____ _____ Group No. _____

Social Security No. of Policy Holder _____ _____

(It is necessary that you provide claim forms for all professional services that may be eligible for insurance coverage)

Who may we thank for referring you _____ _____

Comments: ____ _____ _____ ____ _____

_____

_____

Please complete reverse side

Are you having pain or discomfort at this time? ..... YES NO

2. Have you been a patient in the hospital during the past two years? ..... YES NO
3. Have you been under the care of a medical doctor during the past two years? ..... YES NO

Physician's Name

Address Telephone

4. Have you taken any medication or drugs during the past two years? ..... YES NO
5. Are you now taking any medication, drugs or pills? ..... YES NO

If yes, please list:

6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? ..... YES NO

If yes, please list:

7. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure ..	YES	NO	Stroke .	YES	NO	Hepatitis A (infectious)	YES	NO
Heart Disease or Attack	YES	NO	Artificial Joints (hip, knee, etc.) ...	YES	NO	Hepatitis B (serum) ...	YES	NO
Angina Pectoris	YES	NO	Kidney Trouble .	YES	NO	Venereal Disease	YES	NO
Congenital Heart Disease	YES	NO	Ulcers	YES	NO	A.I.D.S. ..	YES	NO
Heart Murmur	YES	NO	Diabetes .	YES	NO	H.I.V. Positive	YES	NO
High Blood Pressure	YES	NO	Thyroid Problems .	YES	NO	Cold Sores/Fever Blisters	YES	NO
Arteriosclerosis	YES	NO	Glaucoma	YES	NO	Blood Transfusion	YES	NO
Mitral Valve Prolapse	YES	NO	Cosmetic Surgery	YES	NO	Hemophilia	YES	NO
Artificial Heart Valve .	YES	NO	Emphysema ...	YES	NO	Anemia	YES	NO
Heart Pacemaker	YES	NO	Chronic Cough .	YES	NO	Sickle Cell Disease	YES	NO
Heart Surgery	YES	NO	Tuberculosis .	YES	NO	Bruise Easily ...	YES	NO
Rheumatic Fever ..	YES	NO	Asthma	YES	NO	Liver Disease	YES	NO
Arthritis	YES	NO	Hay Fever	YES	NO	Yellow Jaundice	YES	NO
Rheumatism	YES	NO	Allergies or Hives	YES	NO	Epilepsy or Seizures .	YES	NO
Pain in Jaw Joints	YES	NO	Sinus Trouble	YES	NO	Fainting or Dizzy Spells	YES	NO
Cortisone Medicine	YES	NO	Radiation Therapy	YES	NO	Nervousness	YES	NO
Drug Addiction	YES	NO	Chemotherapy	YES	NO	Psychiatric Treatment	YES	NO

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ..... YES NO
9. Do your ankles swell during the day? ..... YES NO
10. Do you use more than two pillows to sleep? ..... YES NO
11. Have you lost or gained more than 10 pounds in the past year? ..... YES NO
12. Do you ever wake up from sleep and feel short of breath? ..... YES NO
13. Are you on a special diet? ..... YES NO
14. Has your medical doctor ever said you have a cancer or tumor? . ..... YES NO
15. Do you have or have you had any disease, condition, or problem not listed? ..... YES NO

If yes, please list: _____

FOR WOMEN ONLY:

Are you pregnant? ☐ Yes, what month? ☐ No Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature Date

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (name of Patient)
and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time sevices are rendered unless financial arrangements have been made. I further understand that a 1½% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient