

REGISTRATION

Patient's name _____
Last First M.I.

Birth date _____ Age _____ Date _____

Single Married Other

Name of spouse/partner _____

If a child, parent's name _____

Address _____

City _____ State _____ Zip _____

Business address _____

Telephone: Home _____ Business _____

Patient employed by _____

Present position _____

Spouse/partner employed by _____

Referred by _____

Purpose of visit? _____

Patient's Social Security number (Only required for Insurance purposes.) _____

Spouse/partner's Social Security number (Only required for Insurance purposes.) _____

Spouse/partner's birth date _____

Name and address of dental insurance company:

Primary _____ Secondary _____

Policy # _____ Policy # _____

Date of last medical examination _____

Do you have or have you ever had:	Yes	No
Anemia	_____	_____
Diabetes	_____	_____
Hepatitis	_____	_____
Allergies	_____	_____
To penicillin	_____	_____
To local anesthetic	_____	_____
Abnormal heart condition	_____	_____
Abnormal bleeding from a cut	_____	_____
Rheumatic fever	_____	_____
Heart murmur	_____	_____

Name of Physician _____

Telephone number _____

Are you taking any medication..... _____

 If so, what _____

Other physical conditions we should be aware of _____

Blood pressure (if known) S _____ / D _____ / _____

Signature _____ Date _____