PATIENT REGISTRATION

Patient is: ☐ Policy Holder ☐ Responsible Party **Today's Date:** _____

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell #: _____ Home #: _____ Work #: _____ Ext.: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Soc Sec #: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Pref. Dentist: _____ Pref. Hyg: _____

Pref. Pharmacy: _____ Pharmacy Phone #: _____

Section 3

Emergency Contact:

Name: _____

Phone: _____

Relationship to patient: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell #: _____ Home #: _____ Work #: _____ Ext.: _____

Relationship to Patient: _____

Birth Date: _____ Age: _____ Soc Sec #: _____ Drivers Lic: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc Sec #: _____ Insured Birth Date: _____

Employer: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Phone #: _____

Ins. Company: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Phone #: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc Sec #: _____ Insured Birth Date: _____

Employer: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Phone #: _____

Ins. Company: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Phone #: _____

OVER

Adams Dental Group, PA

Complete Patient Medical Health History

Patient Name: _____ **Birth Date:** _____ **Today's Date:** _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? If yes please explain and provide physician's name, and office number. ☐ Yes ☐ NO If yes _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ NO If yes explain _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ NO If yes _____

Are you taking any medications, pills or drugs? ☐ Yes ☐ NO If yes please list _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ NO

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ NO

Do you have Acid Reflux and/or Ulcers? ☐ Yes ☐ NO

Do you use tobacco? ☐ Yes ☐ NO

Have you ever been told that you should premedicate with an antibiotic prior to dental treatment? ☐ Yes ☐ NO If yes, why? _____

Women: Are you... ☐ Pregnant/Trying to get pregnant? ☐ Nursing

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Other allergies? If yes _____

☐ Metal ☐ Latex ☐ Sulfa Drugs

☐ Hydrocodone ☐ Acrylic ☐ Local Anesthetics

Are you taking any blood thinners?

☐ Aspirin ☐ Coumadin/Warfarin ☐ Plavix ☐ Other blood thinners? If yes _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ☐ Yes ☐ NO	Cortisone Medicine ☐ Yes ☐ NO	Hemophilia ☐ Yes ☐ NO	Radiation Treatments ☐ Yes ☐ NO
Alzheimer's Disease ☐ Yes ☐ NO	Diabetes ☐ Yes ☐ NO	Heart Surgery/Bypass ☐ Yes ☐ NO	Hepatitis A, B or C ☐ Yes ☐ NO
Anemia ☐ Yes ☐ NO	Easily Winded ☐ Yes ☐ NO	Kidney Dialysis ☐ Yes ☐ NO	Emphysema/COPD ☐ Yes ☐ NO
High Blood Pressure ☐ Yes ☐ NO	Rheumatism ☐ Yes ☐ NO	Arthritis/Gout ☐ Yes ☐ NO	Epilepsy or Seizures ☐ Yes ☐ NO
Heart - Artifical Valve ☐ Yes ☐ NO	Excessive Bleeding ☐ Yes ☐ NO	Organ Transplant ☐ Yes ☐ NO	Artificial Joint ☐ Yes ☐ NO
Shunt ☐ Yes ☐ NO	Sickle Cell Disease ☐ Yes ☐ NO	Asthma ☐ Yes ☐ NO	Fainting Spells/Dizziness ☐ Yes ☐ NO
Heartbeat Irregular ☐ Yes ☐ NO	Blood Disease ☐ Yes ☐ NO	Kidney Problems ☐ Yes ☐ NO	Port Central/PICC IV Line ☐ Yes ☐ NO
Blood Transfusion ☐ Yes ☐ NO	Lupus ☐ Yes ☐ NO	Breathing Problems ☐ Yes ☐ NO	Sjogren's Syndrome ☐ Yes ☐ NO
Liver Disease ☐ Yes ☐ NO	Stoke ☐ Yes ☐ NO	Xerostomia/Dry Mouth ☐ Yes ☐ NO	Low Blood Pressure ☐ Yes ☐ NO
Anxiety/Dental Anxiety ☐ Yes ☐ NO	Cancer ☐ Yes ☐ NO	Glaucoma ☐ Yes ☐ NO	Lung Disease ☐ Yes ☐ NO
Thyroid Disease ☐ Yes ☐ NO	Chemotherapy ☐ Yes ☐ NO	Methemoglobinemia ☐ Yes ☐ NO	Mitral Valve Prolapse ☐ Yes ☐ NO
Parkinson's Disease ☐ Yes ☐ NO	Heart Attack/Failure ☐ Yes ☐ NO	Osteoporosis ☐ Yes ☐ NO	Tuberculosis ☐ Yes ☐ NO
Cold Sores/Fever Blisters ☐ Yes ☐ NO	Heart Murmur ☐ Yes ☐ NO	Pain in Jaw Joints ☐ Yes ☐ NO	Heart Disorder - Congenital ☐ Yes ☐ NO
Heart Pacemaker ☐ Yes ☐ NO	Heart Trouble/Disease ☐ Yes ☐ NO	**Office Only: PreMed** ☐ Yes ☐ NO	**Office Only: No Epi** ☐ Yes ☐ NO

Have you ever had any serious illness not listed above? ☐ Yes ☐ NO If yes _____

If "Yes" provide date(s) on: Heart Surgery/Attack, Stroke, ☐ Joint Replacement, Organ Transplant, Cancer Treatments If yes _____

Comments:

To the best of my knowledge, the questions of this form have been accurately answered. I understand the providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____ Date: _____