PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL PATIENT REGISTRATION

DATE:	
NAME:	
ADDRESS:	
CITY:	ZIP:
E-Mail:	
HOME PHONE:	
CELL PHONE:	
WORK PHONE:	
BIRTHDATE: ___ /___ /___	MALE FEMALE
AGE: MARRIED SINGLE	DIVORCED WIDOWED
SOCIAL SECURITY NO.: _____ /____ /________	
PHARMACY NAME:	
PHARMACY PHONE:	
MEDICAL DOCTORS:	
NAME:	PHONE:
ADDRESS:	
CITY:	ZIP:
MEDICAL SPECIALISTS:	
NAME:	PHONE:
ADDRESS:	
CITY:	ZIP:
NAME:	PHONE:
ADDRESS:	
CITY:	ZIP:

ACCOUNT INFORMATION - PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

YOU

NAME:	
OCCUPATION:	
EMPLOYER:	
BUSINESS ADDRESS:	
CITY:	ZIP:
BUSINESS PHONE:	EXT.:

YOUR SPOUSE

NAME:	
OCCUPATION:	
EMPLOYER:	
BUSINESS ADDRESS:	
CITY:	ZIP:
BUSINESS PHONE:	EXT.:

DENTAL INSURANCE
PRIMARY CARRIER
INSURANCE COMPANY:
GROUP NO.:
EMPLOYEE:
BIRTHDATE: ___ /___ /___
DATE EMPLOYED: ___ /___ /___
UNION OR LOCAL NO.:
INSURED ID#:
EMPLOYEE SOCIAL SECURITY NO.: ___ /___ /____
SECONDARY CARRIER
INSURANCE COMPANY:
GROUP NO.:
EMPLOYEE:
BIRTHDATE: ___ /___ /___
DATE EMPLOYED: ___ /___ /___
UNION OR LOCAL NO.:
INSURED ID#:
EMPLOYEE SOCIAL SECURITY NO.: ___ /___ /____
MEDICAL INSURANCE
INSURANCE COMPANY:

GETTING TO KNOW YOU - IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?

NAME:
RELATIONSHIP:
REFERRED TO US BY:
EMERGENCY CONTACT:
PHONE NUMBER:
ADDRESS:
CITY:
STATE:
ZIP:

REV: 7-1-2010

CONFIDENTIAL

MEDICAL HISTORY

PLEASE PRINT CLEARLY

Are you in good health? ______

Have you been hospitalized in the last two years? Yes ____ No ____ If yes, please explain your condition and treatment ______

Physician's MD names and phone number ______

Are you now under a physician's care for any illness or condition? Yes ____ No ____ If yes, please explain your condition and treatment ______

Are you pregnant? ______ What is your due date? ______

Medications you are now taking:	Dosage	Reason for taking

Do you smoke? ______ How many packs a day? ______

Are you taking aspirin? ______ What dosage? ______

Do you take blood thinners? Yes ____ No ____ What type? ______

Do you now or have you ever taken Bisphosphonates underline type, (Fosamax) (Aredia) (Zometa) (Boniva) (Actonel)

Please check if you have or have had any of the following conditions?

Heart Murmur ____	Kidney Trouble ____	HIV ____	Fainting or Dizziness ____
Mitral Valve Prolapse ____	Ulcers ____	Epilepsy or Seizures ____	Cold Sores ____
Heart Condition ____	Hepatitis A ____	Pain in Jaw ____	Hemophilia ____
Rheumatic Fever ____	Hepatitis B ____	Stroke ____	Hypoglycemia ____
Alzheimer's Disease ____	Hepatitis C ____	Cancer ____	Blood Disease ____
Artificial Heart Valve ____	Emphysema ____	Liver Disease ____	Blood Transfusion ____
Heart Pacemaker ____	Lung Disease ____	Yellow Jaundice ____	Chemotherapy ____
Heart Surgery ____	Tuberculosis ____	Venereal Disease ____	AIDS ____
Chest Pains ____	Drug Addiction ____	Nervousness ____	Allergies ____
High Blood Pressure ____	Diabetes ____	Alcohol Addiction ____	Latex Allergies ____
Low Blood Pressure ____	Excessive Thirst ____	Sinus Trouble ____	Thyroid Disease ____
Psychiatric Care ____	Parathyroid Disease ____	X-ray Cobalt Treat ____	Recent Weight Loss ____
Shortness of Breath ____	Artificial Joint/Hip/Knee Replacement ____		Osteoporosis/Osteopenia ____

Have you ever had an allergic reaction to any drug? ______ Please specify ______

*Women Note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your Physician for assistance.

Doctors notes ______

Have you ever had any illness not checked above? ______

Please describe ______

Signed X ______ Date ______

MEDICAL REVIEW UPDATE

Date	Changes In Medical History	Patient's Signature	Reviewed By
		X	X
		X	X
		X	X
		X	X

REV: 7-1-2010

Patient Health and Medication Update

Patient name ______________________________

Do you have any specific health or dental concerns today? Yes/No
If yes, please explain ______________________________

Have you been hospitalized since your last visit here? Yes/No
If yes, please explain ______________________________

Please list the medications that have been prescribed by your doctor:

Name of Medications	How much and how often?	Why do you take it?

Please list the medications that you have selected on your own (also called "over-the-counter" or OTC). These might include medicines for pain or headache (Tylenol, Motrin ib, Advil), stomach problems (Maalox, Pepto Bismol, Zantac), cough or cold symptoms (Robitussin, Dimetapp, Sudafed), allergies (Benadryl), etc.

Name of Medications	How much and how often?	Why do you take it?

Please list the herbs or other all-natural supplements that you are taking (such as ginseng, St Johns wort, Saw Palmetto, bilberry, etc):

Name of Herb or Supplement	How much and how often?	Why do you take it?

Do you like to drink grapefruit juice? Yes/No
If Yes, how often? ______________

Do you like to drink cranberry juice? Yes/No
If Yes, how often? ______________

Do you regularly take any type of vitamin(s)? Yes/No
If Yes, explain: ______________

Patient Signature ______________________________ Date ______________