DEDICATED DENTAL SERVICE
PATIENT REGISTRATION

ID:_____

First Name _____ **Last Name** _____ **Middle Initial** _____

Patient is: [ ] Policy Holder **Preferred Name:** _____
[ ] Responsible Party

Responsible Party (if someone other than the patient)

First Name _____ **Last Name** _____ **Middle Initial** _____

Address: _____ **Mailing Address** _____

City, State, Zip: _____

Home Phone:_____ **Cell Phone:**_____ **Message Phone:** _____

Birth Date:_____ **SS#** _____ **Drivers Lic:** _____

Patient Information

Address: _____ **Mailing Address** _____

City, State, Zip: _____

Home Phone:_____ **Cell Phone:**_____ **Message Phone:** _____

Birth Date:_____ **SS#** _____ **Drivers Lic:** _____

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**

Employment Status: [ ] Full Time [ ] Part Time [ ] Retired

Student Status: [ ] Full Time [ ] Part Time

Employer ID: _____ **Preferred Dentist:** _____ **Preferred Hyg:** _____

Carrier ID: _____ **Preferred Pharmacy:** _____

Primary Insurance Information **Relationship to insured: [ ] Self [ ] Spouse [ ] Child [ ] Other**

Name of Insured: _____ **Insured Birth Date:**_____

Employer:_____ **Insurance Company:** _____

Address: _____ **Address:** _____

City,State,Zip: _____ **City,State,Zip:** _____

Secondary Insurance Information **Relationship to insured: [ ] Self [ ] Spouse [ ] Child [ ] Other**

Name of Insured: _____ **Insured Birth Date:**_____

Employer:_____ **Insurance Company:** _____

Address: _____ **Address:** _____

City,State,Zip: _____ **City,State,Zip:** _____

DEDICATED DENTAL SERVICE
MEDICAL HISTORY

Patient name _____ **Birth Date** _____

Although dental personnel 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 will receive. Thank you for answering the following questions

Are you under a physician's care now? [ ] Yes [ ] No If yes, please explain:_____

Have you ever been hospitalized or had a major operation? [ ] Yes [ ] No If yes, please explain:_____

_____

Have you ever had a serious head or neck injury? [ ] Yes [ ] No If yes, please explain:_____

Are you taking any medication, pills, or drugs? [ ] Yes [ ] No If yes, please explain:_____

Do you take, or have you taken, Phen-Fen or Redux? [ ] Yes [ ] No If yes, please explain:_____

Have you ever taken Fosamax, Boniva, Actonel or Any other medications containing bisphosphonates? [ ] Yes [ ] No If yes, please explain:_____

Are you on a special diet? **If yes, please explain:**_____ **Women: Are you [ ] Nursing?**

Do you use tobacco? **If yes, please explain:**_____ **[ ] Pregnant/Tryins to get prenant**

Do you use controlled substances? **If yes, please explain:**_____ **[ ] Taking oral contraceptives?**

Are you allergic to any of the following?

[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Acrylic [ ] Metal [ ] Latex [ ] Local Anesthetics [ ] Sulfa Drugs

[ ] Other If yes, please explain: _____

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

[ ] Aids/HIV Positive	[ ] Chest Pains	[ ] Frequent Headaches	[ ] Hypoglycemia	[ ] Rheumatic Fever
[ ] Alzheimer's Disease	[ ] Cold Scores/Fever Blisters	[ ] Genital Herpes	[ ] Irregular Heartbeat	[ ] Rheumatism
[ ] Anaphylaxis	[ ] Congenital Heart Disorder	[ ] Glaucoma	[ ] Kidney Problems	[ ] Scarlet Fever
[ ] Anemia	[ ] Convulsions	[ ] Hay Fever	[ ] Leukemia	[ ] Shingles
[ ] Angina	[ ] Cortisone Medicine	[ ] Heart Attack/Failure	[ ] Liver Disease	[ ] Sickle Cell Disease
[ ] Arthritis/Gout	[ ] Diabetes	[ ] Heart Murmur	[ ] Low Blood Pressure	[ ] Sinus Trouble
[ ] Artificial Heart Valve	[ ] Drug Addiction	[ ] Heart Pacemaker	[ ] Lung Disease	[ ] Spina Bifida
[ ] Artifical Joint	[ ] Easily Winded	[ ] Heart Trouble/Disease	[ ] Mitral Valve Prolapse	[ ] Stroke
[ ] Asthma	[ ] Emphysema	[ ] Hemophilia	[ ] Osteoporosis	[ ] Swelling of Limbs
[ ] Blood Disease	[ ] Epilepsy or Seizures	[ ] Hepatitis A	[ ] Pain in Jaw Joints	[ ] Thyroid Disease
[ ] Blood Transfusion	[ ] Excessive Bleeding	[ ] Hepatitis B or C	[ ] Parathyroid Disease	[ ] Tonsillitis
[ ] Breathing Problem	[ ] Excessive Thirst	[ ] Herpes	[ ] Psychiatric Care	[ ] Tuberculosis
[ ] Bruise Easily	[ ] Fainting Spells/Dizziness	[ ] High Blood Pressure	[ ] Radiation Treatments	[ ] Ulcers
[ ] Cancer	[ ] Frequent Cough	[ ] High Cholesterol	[ ]Recent Weight Loss	[ ] Venereal Disease
[ ] Chemotherapy	[ ] Frequent Diarrhea	[ ] Hives or Rash	[ ] Renal Dialysis	[ ] Yellow Jaundice
[ ] Stomach/Intestinal Disease	[ ] Tumors or Growths			

Have you ever had any serious illness not listed above? [ ] Yes [ ] No if yes, please explain: _____

Comments:_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that 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** _____