Patient Registration & Health History Form

*Name*_____ *Today's Date*_____
*Address*_____ *SS#* _____
*City*_____ *State*_____ *Zip Code*_____ *Email*_____
*Home Phone*_____ *Work Phone*_____ *Cell Phone*_____
Age _____ *Birth Date* _____ *O Single O Married O Divorced O Separated O Widowed*
*Occupation*_____ *Place of Employment*_____
Whom May We Thank for Referring You?
O Family O Friend O Google O Yelp O Consumer Checkbook
O Washingtonian Magazine O Bethesda Magazine O Other _____
In case of an emergency who should be notified? _____ *Phone* _____

Person Responsible for Account _____
*Relation to Patient*_____ *Birth Date*_____ *SS#* _____
Address (if different from patient's) _____ *Phone* _____
*City*_____ *State*_____ *Zip Code*_____ *Email*_____
*Home Phone*_____ *Work Phone*_____ *Cell Phone*_____
Age _____ *Birth Date* _____ *O Single O Married O Divorced O Separated O Widowed*
*Occupation*_____ *Place of Employment*_____
*Business Address*_____ *Phone*_____

Insurance Policy Holder _____
*Insurance Company*_____
Contract # _____ *Group #*_____ *Subscriber #*_____
*Names of other dependents covered under this plan*_____

Is patient covered by <u>additional</u> insurance? O Yes O No
*Subscriber's Name*_____ *Relation to Patient*_____ *Birth Date*_____ *SS#* _____
Address (if different from patient's) _____ *Phone* _____
*City*_____ *State*_____ *Zip Code*_____ *Email*_____
*Home Phone*_____ *Work Phone*_____ *Cell Phone*_____
*Occupation*_____ *Place of Employment*_____
*Insurance Company*_____
Contract # _____ *Group #*_____ *Subscriber #*_____

Reason for Today's Visit _____ *Last Dental Visit* _____
*Previous Dentist*_____ *Last Dental X-Rays*_____
*Address*_____
Check if you have any of the following:

O Bleeding Gums	*O Sensitivity to Biting*	*O Food Impaction between Teeth*
O Sensitivity to Hot	*O Bad Breath*	*O Clicking/Popping*
O Sensitivity to Cold	*O Sensitivity to Sweets*	*O Loose Teeth or Fillings*

Physician's Name _____ *Phone Number* _____
Have there been any changes in your health in the last year? O Yes O No If yes, please describe _____
_____
Have you ever had any serious illnesses, operations or hospitalizations? O Yes O No _____
Have you ever taken? O Phen-Fen O Redux Are you on a special diet? O Yes O No _____
Have you ever had a blood transfusion? O Yes O No
Are you taking any medications, pills or drugs? O Yes O No If so, What? _____
_____
_____

Do you use tobacco? O Yes O No Do you drink alcohol? O Yes O No How Much? _____
Do you use controlled substances? O Yes O No
Please check if you have an ALLERGY to any of the following:

O Aspirin	*O Latex*	*O Metal*	*O Local Anesthetic*
O Penicillin	*O Codeine*	*O Acrylic*	*O Other* _____

Have you taken BISPHOSPHONATES in the past? O Fosamax O Boniva O Other _____
Women:
Are you pregnant/trying to get pregnant? O Yes O No
Taking oral contraceptives? O Yes O No Nursing? O Yes O No

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

AIDS/HIV+	*O Yes O No*	*Heart Pace Maker*	*O Yes O No*
Alzheimer's Disease	*O Yes O No*	*Heart Disease*	*O Yes O No*
Anaphylaxis	*O Yes O No*	*Hemophilia*	*O Yes O No*
Anemia	*O Yes O No*	*Hepatitis A B or C*	*O Yes O No*
Angina	*O Yes O No*	*High Blood Pressure*	*O Yes O No*
Arthritis/Gout	*O Yes O No*	*High Cholesterol*	*O Yes O No*
Artificial Heart Valve	*O Yes O No*	*Hypoglycemia*	*O Yes O No*
Artificial Joint	*O Yes O No*	*HPV*	*O Yes O No*
Blood Disease	*O Yes O No*	*Leukemia*	*O Yes O No*
Breathing Problems	*O Yes O No*	*Liver Disease*	*O Yes O No*
Cancer	*O Yes O No*	*Low Blood Pressure*	*O Yes O No*
Chemotherapy	*O Yes O No*	*Mitral Valve Prolapse*	*O Yes O No*
Chest Pains	*O Yes O No*	*Osteoporosis*	*O Yes O No*
Cold Sores	*O Yes O No*	*Psychiatric Care*	*O Yes O No*
Congenital Heart Disease	*O Yes O No*	*Radiation Treatment*	*O Yes O No*
Convulsions	*O Yes O No*	*Renal Dialysis*	*O Yes O No*
Diabetes	*O Yes O No*	*Rheumatic Fever*	*O Yes O No*
Drug Addiction Emphysema	*O Yes O No*	*Scarlet Fever*	*O Yes O No*
Epilepsy/Seizures	*O Yes O No*	*Shingles*	*O Yes O No*
Excessive Thirst	O Yes O No	*Sinus Trouble*	*O Yes O No*
Frequent Cough	*O Yes O No*	*Stomach Disease*	*O Yes O No*
Frequent Headaches	*O Yes O No*	*Stroke*	*O Yes O No*
Glaucoma	*O Yes O No*	*Tonsillitis*	*O Yes O No*
Hay Fever	*O Yes O No*	*Ulcers*	*O Yes O No*
Heart Murmur	*O Yes O No*	*OTHER (Write Below)*	*O Yes O No*

_____
_____

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 (the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I authorize the dentist to release all information necessary to secure payment of benefits and understand that I am financially responsible for all charges whether or not paid by insurance.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

_____ *Date* _____