PATIENT REGISTRATION

(PLEASE PRINT)

DATE:_____

PATIENT'S NAME: ☐ MR. ☐ MRS. ☐ MS. ☐ DR: _____

FIRST MIDDLE LAST

By what name do you prefer to be addressed? _____

ADDRESS:

_____

STREET APT. # PO BOX

_____

CITY STATE ZIP CODE

HOME PHONE: (____) _____DAYTIME PHONE: (____) _____

CELL PHONE: (____) _____ EMAIL ADDRESS: _____

DATE OF BIRTH: _____SOCIAL SECURITY #: _____

☐ MALE ☐ FEMALE ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

EMPLOYER/SCHOOL IF FULL TIME STUDENT: _____ OCCUPATION: _____

BUSINESS/SCHOOL ADDRESS: _____

IF MINOR, PARENT'S NAME: _____

ADDRESS IF DIFFERENT FROM ABOVE: _____

IF MARRIED:

NAME OF SPOUSE: _____ WORK PHONE: _____ EXT. _____

BUSINESS ADDRESS: _____

PERSON RESPONSIBLE FOR PAYMENT: _____

ADDRESS: _____

REFERRED BY: _____

Name of other family members who are patients here: _____

EMERGENCY CONTACT: _____ PHONE NUMBER: _____

WE ACCEPT CASH CHECK VISA MASTERCARD AMERICAN EXPRESS

DO YOU NEED A DENTAL INSURANCE FORM? ☐ YES ☐ NO NAME OF PRIMARY INSURED: _____

MEDICAL DOCTOR: _____ PHONE: _____

Please describe the reason for your visit today. If you are having a specific problem, please give details.

_____

AUTHORIZATION:

I hereby authorize Drs Ellis and Winokur to release any dental information related to my insurance claim for payment.

SIGNED: _____ DATE: _____

HEALTH HISTORY

YES	NO	
☐	☐	Do you take any prescription medications? Please List: _____ _____
☐	☐	Do you take any over the counter medications including herbal or holistic remedies, vitamins or minerals? Please List: _____ _____
☐	☐	Are you allergic to any medications? Please list_____ _____
☐	☐	Have you been diagnosed with any of the following: heart trouble, heart murmur, mitral valve prolapse, lupus, rheumatic fever, heart valve replacement? Circle all that apply.
☐	☐	Have you ever had a joint replacement? If yes, joint(s) _____ Date of surgery: _____ Name of surgeon: _____
☐	☐	Do you have a pacemaker?
☐	☐	Do you have abnormal blood pressure?
☐	☐	Do you experience abnormal bleeding or clotting from a cut?
☐	☐	Have you ever received a blood transfusion?
☐	☐	Have you ever been told you could not donate blood? If yes, please explain: _____
☐	☐	Have your ever had complications from a tooth extraction? (Dry sockets, bleeding, slow healing)
☐	☐	Have you ever had problems with dental anesthetic? If yes, what? _____ _____
☐	☐	Have you ever had or do you now have hepatitis, tuberculosis, AIDS, VD or any other infectious disease that we should know about? Please specify _____
☐	☐	Are you under a physician's care now? If yes, please explain: _____
☐	☐	Do you have diabetes or Kidney disease? Please specify: _____
☐	☐	Have you ever had an organ transplant? Please specify: _____
☐	☐	Have you had surgery since your last dental visit? If yes, type of surgery: _____ Surgeon's name: _____ Phone # _____
☐	☐	Do you have any other serious health issues or dental concerns we should know about? _____
☐	☐	Women: Are you pregnant or trying to get pregnant?
☐	☐	Are you nursing?
☐	☐	Are you taking oral contraceptives?

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_____