REGISTRATION HISTORY

DATE ____________________

PATIENT'S FULL NAME ____________________ SINGLE ________
AGE ________ DATE OF BIRTH ____________________ WIDOWED ________
NAME OF SPOUSE ____________________ MARRIED ________
IF A CHILD, PARENT'S NAME ____________________ DIVORCED ________
STREET ADDRESS ____________________ PHONE ____________ SEPARATED ________
CITY ____________ STATE ________ ZIP ________ CELL ________
EMAIL ____________________
WHO REFERRED YOU TO OUR OFFICE? ____________________
PATIENT EMPLOYED BY ____________________ PHONE ________
BUSINESS ADDRESS ____________________
PRESENT POSITION ____________________ HOW LONG HELD ________
SPOUSE EMPLOYED BY ____________________ PHONE ________
BUSINESS ADDRESS ____________________
PRESENT POSITION ____________________ HOW LONG HELD ________
PURPOSE OF THIS APPOINTMENT ____________________
IN CASE OF EMERGENCY, WHOM SHOULD BE NOTIFIED ____________ PHONE ________
WHO WILL PAY THIS ACCOUNT ____________________
SOCIAL SECURITY NUMBER ____________________
DO YOU HAVE INSURANCE THAT MAY COVER ANY PART OF OUR PROFESSIONAL SERVICES? YES ____ NO ____
IF SO, NAME OF COMPANY ____________________ POLICY NO. ________

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. My last physical examination was on ____________________
2. Are you now under the care of a physician? . . . . YES NO
   If so, what is the condition being treated? ____________________
3. The name and address of my physician is ____________________
   ____
   ____
4. Have you had any serious illness or operation? . . . . YES NO
   If so, what was the illness or operation? ____________________
5. Do you have or have you had any of the following diseases or problems?
   a. Rheumatic fever or rheumatic heart disease . . . . YES NO
   b. Congenital heart lesions . . . . YES NO
   c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) . . . . YES NO
   d. Allergy . . . . YES NO
   e. Sinus trouble . . . . YES NO

(over)

f. Asthma or hay fever .... YES NO
g. Fainting spells or seizures .... YES NO
h. Diabetes .... YES NO
i. Hepatitis, jaundice or liver disease .... YES NO
j. Arthritis .... YES NO
k. Stomach ulcers .... YES NO
l. Kidney trouble .... YES NO
m. Tuberculosis .... YES NO
n. Low blood pressure .... YES NO
o. Venereal disease .... YES NO
p. Thyroid problem .... YES NO
q. AIDS .... YES NO
r. Tested positive for HIV virus .... YES NO
s. Other ______________________________

6. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? .... YES NO

7. Do you have any blood disorder such as anemia? .... YES NO

8. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your mouth or lips? ... YES NO

9. Are you taking any drug or medicine? .... YES NO
If so, what? ______________________________

10. Are you allergic or have you reacted adversely to any drug or medicine? .... YES NO
If so, what? ______________________________

11. Have you had any serious trouble associated with any previous dental treatment? .... YES NO
If so, explain? ______________________________

____

12. Do you have any disease, condition, or problem not listed above that you think I should know about? ... YES NO
If so, explain? ______________________________

____

13. Are you pregnant? .... YES NO

____
SIGNATURE OF PATIENT

____
SIGNATURE OF DENTIST