



Date _____

Registration / History

Single _____

Widowed _____

Patient's Name _____

Married _____

Name of Spouse _____

Divorced _____

Separated _____

Street Address _____

Phone _____

Cell Phone _____

City _____ State _____ Zip _____

Patient Employed by _____ Phone _____

Business Address _____

Spouse Employed by _____ Phone _____

Business Address _____

Driver's License Number _____

In case of emergency, who should be notified _____ Phone _____

Name of Dental Insurance: _____

Primary _____ Grp# _____ Policy Holder _____

Secondary _____ Grp# _____ Policy Holder _____

Patient's Social Security Number _____ Birthdate _____

Spouse's Social Security Number _____ Birthdate _____

How did you hear about us? _____

ATTENTION MILITARY: Permanent home of record, please. _____

Street Address _____

City _____ State _____ Zip _____

Date of last MEDICAL examination (not dental) _____ Current Age _____

For what _____

Have you been hospitalized in last 5 years _____ if so, for what _____

Do you have or have you had:	Yes	No	Yes	No
Artificial Joint..... (Hip or Knee Replacement)	_____	_____	_____	_____
Cancer or Tumors.....	_____	_____	_____	_____
Diabetes.....	_____	_____	_____	_____
Epilepsy.....	_____	_____	_____	_____
Hepatitis.....	_____	_____	_____	_____
Rheumatic fever.....	_____	_____	_____	_____
Heart murmur or MVP.....	_____	_____	_____	_____
Abnormal heart condition.....	_____	_____	_____	_____
Abnormal bleeding from a cut...	_____	_____	_____	_____
HIV / AIDS.....	_____	_____	_____	_____
Abnormal Blood Pressure.....	_____	_____	_____	_____
Asthma.....	_____	_____	_____	_____
Are you allergic to:				
Penicillin.....	_____	_____	_____	_____
Local Anesthetic.....	_____	_____	_____	_____
Medication or Drugs.....	_____	_____	_____	_____
Latex.....	_____	_____	_____	_____
Peanuts.....	_____	_____	_____	_____
Women: Are you pregnant.....	_____	_____	_____	_____
Have you ever used PhenFen..	_____	_____	_____	_____
Do you use herbal or alternative medication?.....	_____	_____	_____	_____

If allergic to medications or drugs, indicate which ones _____

Are you taking any medication now? Please List _____

So we can serve you better, please list any disability you may have. _____

Other physical conditions of which we should be aware of _____

Name of your physician _____ Phone _____

Are you receiving care now_____ If so, nature of care _____

Are you now receiving other health care Yes No

If so, nature of care	Name of doctor	Phone