

PATIENT REGISTRATION AND HEALTH HISTORY

*** MEDICAL ALERT ***

Last Name: _____ First: _____ F/M Birth Date: _____
Address: _____ Postal Code _____
Home # _____ Cell # _____ Work # _____ Email _____
How did you hear about our office? _____ First Name _____ Last Name _____
Emergency Contact: _____ Phone # _____

CIRCLE ALL THE FOLLOWING CONDITIONS THAT YOU HAVE, OR HAVE HAD IN THE PAST

AIDS	Anemia	Allergies/ Hives	Angina pectoris	Arthritis/ Rheumatism
Artificial heart valve	Artificial joints	Asthma	Blood disorders (specify): _____	
Bronchitis	Bruise easily	Cancer _____	Circulation problems	Cold sores
Congenital heart lesion	Cortisone/ Steroid meds (specify) _____		Diabetes	Drug addiction
Emphysema	Epilepsy	Fainting/ dizziness	Glandular disorders	Glaucoma
Hay fever	Head/ neck injury	Heart disease	Heart attack	Heart murmur
Pacemaker/ Arrhythmia	Heart failure	Heart surgery (specify) _____		Hemophilia
Hepatitis A	Hepatitis B	Hepatitis C	Herpes	High blood pressure
Low blood pressure	HIV positive	Hyperglycemia	Hypoglycemia	Jaundice
Mitral valve prolapse	Liver disease	Lung disease	Malignant	Lupus
			Hyperthermia	
Mental/ Nervous disorder	Kidney disease	Organ transplant	Psychiatric treatment	Radiation treatment
Rheumatic/ Scarlet fever	Chemotherapy	Sickle cell disease	Sinus trouble	Stomach disease/
				Ulcers
Intestinal problems	Stroke	Thyroid disease	Tuberculosis	Venereal disease
Other (specify) _____				

ARE YOU ALLERGIC OR HAVE YOU REACTED TO ANY OF THE FOLLOWING MEDICATIONS? PLEASE CIRCLE

Acetaminophen/ Tylenol	Amoxicillin	Aspirin	Codeine	Clindamycin
Demerol	Diazepam (Valium)	Erythromycin	Local Anesthetic	Lorazepam (Ativan)
Metronidazole	Nitrous Oxide	Novocaine	Penicillin	Percocet
Sleeping pills	Sulpha Drugs	Triazolam (Halcion)		

Are you aware of being allergic to any other medications or substances? (specify): _____

PLEASE LIST ANY PRESCRIPTION OR NON-PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING:

When was your last dental examination and/or dental x-rays? _____
When was your last medical examination with a physician? _____
What is your physician's name? _____ Phone: _____
Do you smoke? YES/ NO If yes, how long have you smoked, and how many per day? _____
For **WOMEN** only: Are you pregnant? YES/ NO If yes, what is the expected due date? _____

CONSENT TO TREATMENT

1. I certify that the above information is correct to the best of my knowledge.
2. I authorize the doctor upon consultation and direct consent from the patient/ guardian to perform diagnostic procedures.
3. I understand that I am responsible for any fees not covered by my dental insurance

Date:

Signature:

Patient () Parent () Guardian ()
Please check the applicable category