PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT INFORMATION

DATE:______________________________

NAME:__________________________________
BIRTHDATE:______________________________ AGE:_____________ M / F
HOME PHONE:____________________________ CELL:______________________________
PREFERRED NAME:______________________
ADDRESS:____
CITY, STATE, ZIP:____
MARRIED / SINGLE / DIVORCED / WIDOWED
SS#:_______________________________________
OCCUPATION:____
EMPLOYER:______________________________ WORK #:__________________EXT:_____
E-MAIL:____
DRIVER'S LICENSE NO.:_____________________________________
NAME OF PERSON WHO BROUGHT YOU (If under 18):_________________________
WHO IS RESPONSIBLE FOR ACCOUNT: SELF / SPOUSE / PARENT / GUARDIAN

SPOUSE / PARENT / GUARDIAN INFORMATION

NAME:____
SS#:_____________________________________ DOB:_______________________________
MARRIED / SINGLE / DIVORCED / WIDOWED
ADDRESS:____
CITY, STATE, ZIP:____
HOME PHONE:_____________________________ CELL:______________________________
EMPLOYER:____
WORK PHONE:___________________________
EMAIL:____
DRIVER'S LICENSE NO.:_____________________________________

HOW DID YOU FIND OUT ABOUT US?____

NAME (IF PATIENT):____

DENTAL INSURANCE INFORMATION

NAME OF POLICY HOLDER:____
ADDRESS:____
CITY, STATE, ZIP:____
HOME PHONE:_____________________________ CELL:______________________________
WORK PHONE:____________________________ EXT::____________
SS#:______________________________________ CONTRACT #:______________________
INSURED DOB:_____________________________ RELATIONSHIP TO PT:_______________
EMPLOYER:_______________________________ GROUP #:__________________________
INSURANCE CO:____
INS CO ADDRESS:____
CITY, STATE, ZIP:____
INS CO PHONE # _(________)____

IN CASE OF
EMERGENCY - CONTACT:____________________________**PHONE#:**________________________

CLOSEST RELATIVE NOT LIVING WITH YOU (DIFFERENT FROM ABOVE)

NAME:__________________________________ RELATIONSHIP:___________________
HOME #:_______________________________ CELL:____________________________
WORK #:_______________________________
ADDRESS:____
CITY, STATE, ZIP:____

1. Are you having pain or discomfort at this time? .... YES NO
2. Have you been a patient in the hospital during the past two years? .... YES NO
3. Have you been under the care of a medical doctor during the past two years? .... YES NO

Physican's Name ______________________

Address ______________________ Telephone ______________________

4. Has your doctor instructed you to be pre-medicated for your dental visits? .... YES NO
5. Have you taken any medication or drugs during the last two years? .... YES NO
6. Are you now taking any medication, aspirin, blood thinners, drugs, or pills? .... YES NO

If yes, please list: ______________________

7. Do you have any allergies? .... YES NO

If yes, please list: ______________________

8. Indicate which of the following you have had or have at present, circle "YES" or "NO" to each item.

Heart Failure	YES	NO	Stroke	YES	NO	Hepatitis A (infectious)	YES	NO
Heart Disease or Attack	YES	NO	Artificial Joints (hip,knee,etc.)	YES	NO	Hepatitis B (serum)	YES	NO
Angina Pectoris	YES	NO	Kidney Trouble	YES	NO	Hepatitis C	YES	NO
Congenital Heart Disease	YES	NO	Ulcers	YES	NO	Venereal Disease	YES	NO
Heart Murmur	YES	NO	Diabetes	YES	NO	AIDS / HIV Positive	YES	NO
High Blood Pressure	YES	NO	Thyroid Problems	YES	NO	Osteoporosis	YES	NO
Arteriosclerosis	YES	NO	Glaucoma	YES	NO	Cold Sores / Fever Blisters	YES	NO
Mitral Valve Prolapse	YES	NO	Cosmetic Surgery	YES	NO	Blood Transfusion	YES	NO
Artificial Heart Valve	YES	NO	Emphysema	YES	NO	Hemophilia	YES	NO
Heart Pacemaker	YES	NO	Chronic Cough	YES	NO	Anemia	YES	NO
Heart Surgery	YES	NO	Tuberculosis	YES	NO	Sickle Cell Disease	YES	NO
Rheumatic Fever	YES	NO	Asthma	YES	NO	Bruise Easily	YES	NO
Arthritis	YES	NO	Hay Fever	YES	NO	Liver Disease	YES	NO
Rheumatism	YES	NO	Allergies or Hives	YES	NO	Epilepsy or Seizures	YES	NO
Pain in Jaw Joints	YES	NO	Sinus Trouble	YES	NO	Fainting or Dizzy Spells	YES	NO
Cortisone Medicine	YES	NO	Radiation Therapy	YES	NO	Nervousness	YES	NO
Drug Addiction	YES	NO	Chemotherapy	YES	NO	Psychiatric Treatment	YES	NO

9. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? .... YES NO
10. Do your ankles swell during the day? .... YES NO
11. Do you ever wake up from sleep and feel short of breath? .... YES NO
12. Are you on a special diet? .... YES NO
13. Has your medical doctor ever said you have cancer or a tumor? .... YES NO
14. Do you have or have you had any disease, condition, or problem not listed? .... YES NO

If yes, please list: ______________________

15. Do you smoke? .... YES NO How much? ____________
16. Do you chew tobacco, use snuff, or dip? .... YES NO How much? ____________
17. Do you have difficulty opening your mouth wide? .... YES NO Any Clicking or Popping? .... YES NO

FOR WOMEN ONLY:

Are you pregnant? .... YES NO If yes, what month? ____________

Are you nursing? .... YES NO Are you taking birth control pills? .... YES NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Consent:

The undersigned hereby authorizes Millhopper Family Dentistry to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the patient and further authorize and consent that the doctor choose and employ such assistance as deemed fit. I understand the use of anesthetic agents embodies a certain risk.

Patient Signature ______________________ Date ______________________

If patient is under age 18:

Parent Signature ______________________ Date ______________________