HEALTH HISTORY & REGISTRATION

PATIENT INFORMATION			
Last Name:	First Name: M.I.:		
Home Phone:	Cell Phone:		
E-mail Address:			
Mailing Address:	City:	State:	Zip:
Date of Birth: Age:	Gender:	Marital Status:	
Who may we thank for referring you to our office?			
Emergency Contact Name:	Relationship:	Phone:	
If you are completing this form for another person, what is your name and relationship to that person:	Name: Relationship:		

DENTAL INSURANCE INFORMATION	
Insured's Name	Insurance Co.
Insurance Co. Address	Insured's Employer
Group #	Local #

DENTAL HISTORY	
What is the reason for your visit today?	
How long has it been since you've seen a dentist?	
Name of Previous Dentist:	City, State:

MEDICAL HISTORY
Do you have any current health problems?
Do you have a preferred pharmacy? *(e.g. CVS Ina / Thornydale)*
What Medications are you currently taking: *(If you have a medication list, please provide to reception)*
Please list any allergies:

Please circle or otherwise indicate any of the following which you have had, or presently have:

Anemia	Epilepsy	Mitral Valve Prolapse
Arthritis	Fainting	Osteoporosis
Artificial Heart Valves	Glaucoma	Pacemaker/ Heart surgery
Artificial Joints	Headaches	Radiation Treatment
Asthma	Heart Murmur	Respiratory Disease
Back Problems	Heart Problems:	Rheumatic/Scarlet Fever
Cancer	Hemophilia	Shingles
Chemical Dependency	Herpes	Shortness of Breath
Chemotherapy	Hepatitis	Skin Rash
Circulatory Problems	High Blood Pressure	Stroke
Cortisone Treatments	HIV Positive	Thyroid Disease
Cough (Persistent)	Jaw Pain	Tobacco Use
Dementia / Alzheimer's Disease	Kidney Disease or Malfunction	Ulcer/Colitis
Diabetes	Liver Disease	Venereal Disease

Patient/Guardian Signature: _____ Today's Date: _____