Registration Form

Date: _____ Male____ Female____ Date of Birth:_____

Name: _____ Social Security #: _____

Address: _____ Home Phone: _____
House # Street Apt #

_____ Cell Phone: _____
City State ZIP

Email: _____ Texas Driver's License #: _____

Employed by: _____ Job position:_____

Work phone:_____ Work Address:_____

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Dental Insurance Company: _____ Policy #:_____

Dental Insurance Address: _____

Name on Insurance Policy: _____ Ins Co Phone: _____

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Name of Spouse: _____ Social Security #:_____

Date of birth: _____ Work Phone #:_____

Spouse Employed by: _____

****

REFERRED TO OUR OFFICE BY:

_____
Name

_____
Address

_____
City State ZIP

CONTACT IN CASE OF EMERGENCY

_____
Name

_____
Relationship

_____
Phone

****

What is your chief reason for coming to our office? _____

Are there any special conditions we should know about? _____

METHOD OF PAYMENT: CASH_____ CREDIT CARD_____ CHECK_____

<u>I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the cost of my dental treatment.</u> I have read all of the information on this sheet and have completed the answers. I certify that this information is true and correct to the best of my knowledge.

_____
Signature

Health History

Patient Name: _____ **Birth date:** _____

1. Are you in good health? YES NO

2. Any change in your health in the past year? YES NO

3. My medical doctor is (NAME)_____ Phone_____

4. Have you had any serious illness or operation? YES NO Explain:_____

_____

5. Have you had any abnormal bleeding with tooth extraction or other surgery? YES NO

6. Do you bruise easily? YES NO

7. Have you ever had a transfusion? YES NO

8. **MEDICINES YOU ARE TAKING:**

Antibiotics	YES	NO	*
Coumadin or other blood thinners	YES	NO	*
Blood pressure medication	YES	NO	*
Digitalis or other heart drugs	YES	NO	*
Nitroglycerine	YES	NO	*
Antihistamines	YES	NO	*
Insulin or other med for diabetes	YES	NO	*
Cortisone or steroids	YES	NO	*
Oral contraceptives	YES	NO	*
Vitamins	YES	NO	
Herbal Supplements	YES	NO	

9. **Are you <u>ALLERGIC</u> to any of the following?**

Local anesthetics or numbing	YES	NO
Penicillin	YES	NO
Sulfa drugs	YES	NO
Barbiturates or sleeping pills	YES	NO
Aspirin	YES	NO
Iodine	YES	NO
Codeine or other narcotic	YES	NO
Latex gloves	YES	NO
Other_____		

****

Bisphosphonate drugs (Fosamax, Boniva, Aredia, Actonel, Zometa) **used in cancer and osteoporosis treatment. YES NO**

10. Please list drugs you are **<u>ALLERGIC</u>** to:_____

11. Please list any **medicines** taken regularly:_____

12. Do you now have or have you had in the past any of the following diseases or problems?

___ALLERGIC to other things: _____
_____
___Asthma
___Hives or rash
___AIDS
___HIV Positive
___Syphilis
___Herpes
___Other sexually transmitted diseases
___GERD (Reflux Disease)
___High blood pressure
___Heart attack
___Stroke
___Chest pain on exertion
___Shortness of breath
___Do your ankles swell?
___Excessive bleeding
___Damaged heart valves
___Mitral Valve Prolapse (MVP)
___Heart murmur
___Rheumatic fever
___Pacemaker
___Thyroid problems
___Snoring
___Sleep Apnea

___Diabetes
___Frequent thirst
___Any implants?
___Breast
___Joint (knee or hip)
___Dental
___Chin
___Other_____
___Smoke cigarettes
___Swollen lymph nodes
___Thrush
___Yeast infections
___Cold sores
___Dry mouth
___Shingles
___Hepatitis
___Cancer
___Seizures
___Osteoporosis
___Diarrhea
___Epilepsy
___Kidney problems

<u>WOMEN</u>
___Pregnant at this time
___Nursing at this time
___Menstrual problems
___Menopause

<u>OTHER</u>
Anything else we should know about? _____
_____

<u>I have read all of the information on this sheet and have completed the answers. I certify that this information is true and correct to the best of my knowledge.</u>

_____ _____
Signature **Date**