REGISTRATION AND HEALTH HISTORY

Name	Single	Married	Long-Term Partner	Divorced	Separated	Widowed

Social Security number	Birthdate	Home phone	Business phone

Address	City	State	Zip

Employed by	City	State	Zip

Present position	Mobile Phone

Spouse/partner's name

Spouse/partner's Social Security number	Spouse/partner's birthdate	Business phone

Spouse/partner employed by	City	State	Zip

Present position	How long held	State

Referred by	Address

Who will pay for this account?

Name of your dental insurance company and subscriber ID #

Name of your spouse/partner's dental insurance company and subscriber ID #

It is important that I know about your dental and medical history. Many things have a direct bearing on your dental health. I will review the questionnaire and discuss it with you in detail. Information you give me is strictly confidential and will not be released to anyone without your written permission.

MEDICAL HISTORY

Physician's name ______________________ Date of last physical exam ______________

Birthdate ______________ Age ________

Do you have or have you had any of the following. Please indicate with Check mark (✔)

___ Any heart problems
___ High blood pressure
___ Low blood pressure
___ Circulatory problems
___ Nervous problems
___ Radiation treatments
___ Excessive bleeding
___ HIV/AIDS
___ Allergies to anesthetics

___ Allergies to medicines or drugs
___ Allergies to:
____
____
____
___ Anemia
___ Arthritis
___ Asthma

___ Eating Disorder
___ Diabetes
___ Hepatitis
___ Herpes
___ Malignancies
___ Measles
___ Mumps
___ Psychiatric care
___ Rheumatic Fever

___ Scarlet Fever
___ Sinus Problems
___ Stroke
___ Typhoid Fever
___ Tonsillitis
___ Tuberculosis
___ Ulcer
___ Venereal Disease
___ Other

Are you pregnant ________ Blood Pressure: S____/D____/____

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment.

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Date ______________ Your signature ______________________