

PATIENT REGISTRATION & MEDICAL HISTORY

Patient Name, Date of Birth, Male, Female, Married, Single, Address, City, State, Zip, Home Phone, Work Phone, Cell Phone, Employer, Occupation, SS#, Spouse's Name, Spouse's Date of Birth, Spouse's Employer, Spouse's Wk Phone, SS#, Dental Insurance Name, I.D.#, Group #, Insurance Mailing Address, Insured's Name, In case of emergency, who should be notified?, Phone #:

Whom may we thank for referring you? (Please use full name)

MEDICAL HISTORY

Physician's Name, Date of Last Physical

Have you ever had any of the following? (Place an X by all that apply)

- Coronary Artery Disease, Heart Attack, Angina, Arrhythmia, Mitral Valve Prolapse, Artificial Heart Valves, High Blood Pressure, Circulatory Problems, Tonsillitis, Arthritis, Artificial Joints, Osteoporosis, Back Problems, Eye Disorders, Epilepsy, Chronic Headaches, Stroke, Cancer, Radiation Treatment, General Allergies, Allergies to Anesthetics, Latex Allergy, Respiratory Disease, Asthma, Sinus Problems, Hepatitis, Liver Disease, Chemical Dependency, Psychiatric Care, Immunosuppressive Medications, HIV/AIDS, Special Diet, Recent Weight Loss, Diabetes/Family History, Ulcer/Colitis, Swollen Neck Glands, Thyroid, Rheumatic Fever, Tuberculosis, Venereal Disease, Anemia/blood problems, Bleeding Disorders, Other

Do you require pre-medication before dental appointments? If so, what?

Are you taking any anticoagulants: such as aspirin or coumadin?

Do you have any drug allergies or have you ever had a adverse reaction to any medication?

If so, what? Are you taking any medications at this time?

Please list all medications:

If patient is child, what is his or her weight? Do you suspect that you are pregnant?

If so, how many months? Are you nursing?

THE ABOVE INFORMATION IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND IS ONLY FOR USE IN MY TREATMENT, BILLING AND PROCESSING OF INSURANCE FOR BENEFITS FOR WHICH I AM ENTITLED. I WILL NOT HOLD DR. GOLD OR ANY MEMBER OF HIS STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

DATE SIGNATURE

E-Mail Address (to be used only for communication with our office)

Reviewed by Date: