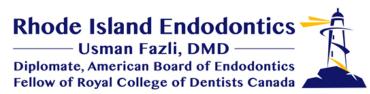
Patient Registration

PATIENT I	INFORM/	NOITA																	
First Name					Mid	dle In	itial		La	ast Na	me								
Nickname				Gende	r 🔲	Male		Fema	ale [☐ Oth	ner		Birth Dat	te				Age	
E-mail				•	•														
Address					С	ity							State			Z	IP Code		
Phone							Home	Э		Cell									
WHO CAN WE THANK FOR REFERRING YOU TO OUR PRACTICE?																			
Referring	g Doctor	☐ Curr	ent Patien	t	☐ Inte	ernet			Insura	nce			Other:						
Referral Nan	ne																		
RESPONSIBLE PARTY (if self is selected, please skip to the next section)																			
☐ Self		☐ Spo	use		☐ Fa	ther			Mothe	r] (Other:						
First Name							Last N	lame											
Birth Date					Age			Telep	ohone										
Address						City							State			Z	IP Code		
INSURAN	CE INFO	RMATIO	ОИ																
PRIMARY I	DENTAL II	NSURAI	NCE CON	IPANY				S	SECONDARY DENTAL INSURANCE COMPANY										
Primary Poli	cy Holder	First		Last				Р	rimary	Policy	/ Holde	er	First			Last			
Birth Date			G		☐ Mal	e [☐ Fema	ale B	Birth Da	ite			1 1100	G	ender		Male		Female
Relationship	to Patient							R	Relation	ship t	o Patie	ent							
Insurance Co. Name						Ir	Insurance Co. Name												
Address								Α	ddress	3									
City			State		ZIP C	ode		С	ity					State	•		ZIP Cod	le	
Telephone								Т	elepho	ne			l				1		
Insurance ID)#							Ir	nsuran	ce ID #	ŧ								
Group #								G	iroup #	:									
								l .											
EMERGEN	CY CON	TACT																	
First Name								Last	Name										
Telephone									tionshi	n to D	ationt								

Patient Registration

									ationt ite	giotia	LIOII	
HEALTH HISTOR	Υ											
Height					Weig	ht						
Are you under the car	re you under the care of a physician? If yes, please complete the line below.								☐ Yes	☐ No		
Date of Last Visit Physician Name						Physician						
Preferred Pharmacy Pharmacy Location Pharmacy Phone								Pharmacy Phone				
Have you had any recent or scheduled surgeries?										☐ No		
If yes, please describe												
Do you smoke or use tobacco?										☐ No		
Are you taking Bispho	osphonates?								☐ Yes	☐ No		
How long?		Oral	☐ Ini	ectable		lıv	Last tre	eatment date?				
How long?												
Are you pregnant?		☐ Ye	ae	☐ No		If ves. n	umber of	f weeks				
Are you nursing?		☐ Ye							☐ Yes	☐ No		
Are you nursing?											thods	
Do you have, or have had, any of the following?												
	Yes	No				•	Yes N	lo		Yes	No	
Abnormal Bleeding			Emphysem	а				Mitral Valve Pro	lapse			
Alcohol Abuse			Epilepsy					Osteoporosis				
Allergies	Allergies			Fainting Spells				Pace Maker				
Anemia			Fever Blisters					Psychiatric Prob	olems			
Angina Pectoris			Glaucoma					Radiation Thera	ру			
Artificial Bones			HIV+ AIDS					Rheumatic Feve	r			
Artificial Heart Valve			Heart Attack					Seizures				
Artificial Joints			Heart Surgery					Shingles				
Asthma			Hemophilia					Sickle Cell Disea	ase			
Blood Transfusion		Hepatitis					Stroke	Stroke				
Cancer - Chemothera		High Blood Pressure					Thyroid Problem					
Congenital Heart Defe	High Cholesterol					Tuberculosis	Tuberculosis					
Diabetes Kidne				idney Problems				Ulcers	Ulcers			
Difficulty Breathing			Liver Disease					Yellow Jaundice				
Drug Abuse			Low Blood	Pressure								
Is there any disease, condition, or problem that you think our office should know about that is not listed above? If yes, please list below.												



				Pat	ient Re	gistra	luon						
MEDICATIONS	S												
Please list all medications, over the counter and herbal supplements, that you are currently taking													
(include medication name, dosage and frequency):													
ALLERGIES/F	REACTIONS												
	c to, or had a reaction t	to any of the following	?										
7 ii o you allorgic	o to, or mad a rodottom t												
A tt		Yes	No	A. data .		Yes	No						
Aspirin				codeine									
Dental Anesthetic	CS			rythromycin									
Jewelry				atex									
Metals				enicillin									
Tetracycline				Other									
Please list any	allergy/reaction that yo	ou have or have had th	nat is no	t listed above.									
45515161141													
ADDITIONAL	NOTES/COMMENTS	:											
FORM COMPL	ETION												
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.													
There may be an increased risk of COVID -19 exposures at this time. I also understand it is possible to be exposed to COVID during any appointment that includes close human contact. I understand I may have been exposed to COVID at any time prior to my treatment at this office.													
appointment that	_	ontact. Tunderstand i ma	ly nave b		treatment a	at this on	ice.						
Signature of	Patient	_		Parent Under Durchle Rever of Atterney									
	Legal Guardia	<u> </u>		Agent Under Durable Power of Attorney									
Printed Name	First Name		,	at Nama									
	First Name		L	st Name									
Signature of Patie	ent, Parent or Guardian				Date								