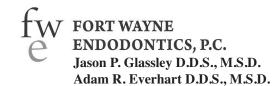


NAME:			
	First	Last	

Allergies Circle all the			local anesthetic	-	lium sulfa
Women Taking birth	ibuprot		-	Other:	
Taking on the	control pins: $\square$ ye	-		If yes, which trimest	
		MEDICAL HISTO	ORY	ii jes, wiiieli tillilest	
Cardiovascular (heart) High Blood Pressure	Yes	Nerves & Sensory Severe Headaches	Yes	Gastrointestinal Ulcers	Yes
Heart Attack		Fainting/Dizzy Spel	ls	Hepatitis	
If so, when?		Epilepsy/Seizures		When?	
Angina/Chest Pain If so, when?		Trigeminal Neuralgi Other:		Type? Liver Disease	
Take Daily Aspirin		Other.	_	Cirrhosis	
Coumadin/Blood Thinn	ers	Respiratory		Cilliosis	
Heart Murmur		Sinus Problems		Hematologic (blood	D
Mitral Valve Prolapse		Allergies or Hives		Stroke	-)
Rheumatic Fever		Asthma		When?	
Congenital Heart Defect	t	Use Inhaler?	<del></del>	Anemia	
Prosthetic Heart Valve		COPD		Prolonged bleeding	
Heart Pacemaker		Tuberculosis		Leukemia	
Heart Surgery				HIV/AIDS Positive	
If so, when?		Endocrine (hormon	nal)		
Other Heart Problems		Diabetes	<u></u>	Urinary	
If yes please describe	:	Take insulin?		Urinate frequently	
		Thyroid Disease		Kidney problem	
Dermal/Musculoskelet	al	<b>Other Conditions</b>			
Sore Jaw Muscles/Joints	s	Enlarged Node/Glar	nd	Osteoporosis	
Arthritis		Use Tobacco, Alcoh	ol	Bisphosphonate use	
Artificial Joint		Atypical Facial Pain		Previous slow healing	ng
Mouth Ulcers/Sores		Cancer/Chemo/Radi	at	Recent travel out of	U.S
Have you been instructed (such as: prior infective PLEASE LIST ALL MEDICIN	endocarditis, artifici	al joints, unrepaired			
Dental Information	Circle all that apply	, Diffio	cult to Numb	Anxious	
	ooth Sensitivity to C		odontic Therapy	Headaches/Neck	Pain
Recent Swelling T	rauma to teeth curren	nt/past Recei	nt Dental Work		
I hereby acknowledge that a ty to ask any questions I may			as been made availa	ble to me. I have been giv	en the opportuni-
<b>Patient or Guardian</b>				<b>Date:</b>	
I understand that the informa sary dental services that I m and that complications, whice dentist for a permanent restor	ay need during diagnosish may result in tooth los	s and treatment, includin s or necessitate further tr	g x-rays. I understar eatment, may occur.	nd that treatment is no gua	rantee of success
Patient or Guardian				Date:	



## **Patient Registration**

Today's Date:

Patient Information	nformation Every line must be completed before services can be rend				
Check: $\square$ Mr. $\square$ Mrs. $\square$ Ms.	□Dr. □Rev				
Patient's Full Name					
Nickname	First	Last	Middle		
Address		City	State Zip		
Date of Birth Socia	l Security No	•	•		
Primary Phone#:()	Texting: \( \subseteq \text{Yes} \)	No Secondary Pl	hone #: <u>(</u> )		
Person to Contact in Case of Emer	gency	Phor	ne: ( )		
Family Dentist:					
Person Responsible for Account/P	ayment (Guarantor):_				
Same Address? ☐ Yes ☐ No					
<b>Dental Insurance Information</b>					
Name of Insured		<b>_</b>	Male   Female		
Relationship to Patient: $\square$ S	elf Spouse	□Parent □Oth	ner		
Social Security No	- Date of B	irth	Phone ()		
Employer	Insurance (	Со			
Ins. Group No	Insurance (	Co. Phone ( )			
Please inform us if you have secon					