TIME 10:14 AM DATE 3/21/2016

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Emergency Contact

Emergency Contact #

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Time 10:12 AM | Curless Dental LLC | Date 3/21/2016

Medical Hx 0229 update(Copy)

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Medical Doctor (physician) name:

Have you been hospitalized or had surgery, in the last 7 years? Yes No If yes

Have you ever had a serious head or neck injury? Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel, or bisphosphonates for osteoporosis? Yes No If yes

Do you use any form of tobacco? Yes No If yes

Do you require Premedication (Antiobiotics) before your dental appointment? Yes No If yes

Do you have a family history of head, neck, and/or oral cancer? Yes No If yes

Are you taking any medications, pills, drugs, or vitamins? Please list below: Yes No

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics
Amoxicillin	Tetracycline	Erythromycin	Ibuprofen

Other Allergies? Yes No If yes

Do you use controlled substances? Yes No If yes

Do you have, or have you had, any of the following? Check YES if it applies.

AIDS/HIV Positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Radiation Treatments Yes No
Alzheimers/Dementia Yes No	Diabetes Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Herpes Yes No	Rheumatic Fever Yes No	Angina Yes No
Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No	Arthritis/Gout Yes No
Epilepsy or Seizures Yes No	High Cholesterol Yes No	Scarlet Fever Yes No	Artificial Heart Valve Yes No
Excessive Bleeding Yes No	Hives or Rash Yes No	Shingles Yes No	Artificial Joint Yes No
Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No	Asthma Yes No
Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No	Blood Disease Yes No
Frequent Cough Yes No	Kidney Problems Yes No	Blood Transfusion Yes No	Frequent Diarrhea Yes No
Leukemia Yes No	Breathing Problems Yes No	Frequent Headaches Yes No	Liver Disease Yes No
Stroke Yes No	Bruise Easily Yes No	Genital Herpes Yes No	Low Blood Pressure Yes No
Swelling of Limbs Yes No	Cancer Yes No	Glaucoma Yes No	Lung Disease Yes No
Thyroid Disease Yes No	Chemotherapy Yes No	Mitral Valve Prolapse Yes No	Chest Pains Yes No
Heart Attack/Failure Yes No	Osteoporosis Yes No	Tuberculosis Yes No	Cold Sores/Fever Blisters Yes No
Heart Murmur Yes No	Pain in Jaw Joints Yes No	Tumors or Growths Yes No	Congenital Heart Disorder Yes No
Heart Pacemaker Yes No	Parathyroid Disease Yes No	Ulcers Yes No	Heart Trouble/Disease Yes No
Anxiety / Depression Yes No	STI / STD's Yes No	Yellow Jaundice Yes No	Crohn's Disease Yes No
Ulcerative Colitis Yes No	Clotting Disorder Yes No		

Have you ever had any serious illness not listed Yes No If yes

Comments:

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.

Signature of Patient, Parent or Guardian:

X Date:_____