Eating to Fuel Health

Patient Registration and Medical History

Patient _____ Phone # _____ E-mail _____

Street Address _____ City _____ State _____ Zip _____

Sex ☐M ☐F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Student

Patient's Social Security # _____ Name of School or College _____ City _____

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Spouse or Parent Name _____ Birthdate _____ Relationship to Patient _____

Employed by _____ Business Address _____

Spouse or Parent Social Security # _____ Business Phone _____

Name of Insured _____ Insurance ID# _____ Group # _____

Name of Insurance Company _____ Address _____

Do You Have Additional Dental Insurance? If Yes, Please See Receptionist.

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of last Physical _____

Have you ever had any of the following? (check boxes that apply):

- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Artificial Heart Valves or Joints
- ☐ Recent Weight Loss
- ☐ Back Problems
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Cancer
- ☐ Psychiatric Care
- ☐ Chronic Diarrhea
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ General Allergies
- ☐ Blood Disease
- ☐ Arthritis
- ☐ Special Diet
- ☐ Swollen Neck Glands
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ "A.I.D.S." or Other Immunosuppressive Disorders
- ☐ Stroke
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Hemophilia

Tobacco use? ☐ Current ☐ Former ☐ Never

Do you have any drug allergies? _____Have you ever had an adverse reaction to any medication? _____

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

Have you ever responded adversely to medical or dental treatment? _____

Are you under the care of a physician? ☐Yes ☐No For what conditions? _____

If patient is a child, what is his/her weight? _____

Woman: Do you suspect that you are pregnant? ☐Yes ☐ No Are you nursing? _____

Is there anything else we should know about your medical history? _____

Person to contact in case of emergency _____ Phone _____

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 my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____