REGISTRATION ----------

Patient's name: _____
Last First M.I.

Birth date: _____ Age: _____ Date: _____

Long-Term

□ Single □ Married □ Partner □ Separated □ Widowed □ Divorced

Name of Spouse/Partner: _____

If a minor, parent's name(s): _____

Street Address: _____

City: _____ State: _____ Zip: _____

Business address: _____

Telephone(s): _____
HOME PHONE CELL PHONE

_____
BUSINESS PHONE

Patient employed by: _____

Present position: _____
How long held?

Spouse/Partner employed by: _____

Present position: _____
How long held?

Referred by: _____

Who will pay this account? _____

Purpose of visit: _____

Patient's Social Security number: _____

Email address: _____

Spouse/Partner's Social Security Number: _____

Spouse/Partner's birth date: _____

Name and address of dental insurance company:

_____ _____
Primary Secondary

_____ _____

_____ _____
Policy Number Secondary Policy Number

Date of last medical examination: _____

Do you currently, or have you ever had: YES NO

Anemia …….. _____ ……..... _____

Diabetes ……. _____ ……. _____

Hepatitis ……. _____ …….. _____

Allergies ……. _____ ……. _____

To penicillin? …….. _____ ……. _____

To local anesthetic? …….. _____ ……. _____

Abnormal heart condition …… _____ ……. _____

Abnormal bleeding from a cut …… _____ ……. _____

Rheumatic fever …….. _____ ……. _____

Heart murmur …….. _____ ……. _____

Are you under the care of a physician now? …….. _____ ……. _____

Are you taking any medication(s)? ……..…… _____ ……. _____

If so, please list _____

_____

Name of physician: _____

Physician's telephone number: _____

Other physical conditions we should be aware of: _____

_____

Blood Pressure (if known) ……..S _____ / D _____ / _____

SIGNATURE: _____ Date: _____

Date	Service rendered	Charge	Credit	Balance