PATIENT REGISTRATION

Date: _____

Patient Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Home Address: _____ City: _____ Zip: _____ How Long? _____
Street

Birth Date: _____ Age _____ Single _____ Married _____ Div. _____ Sep. _____ Widowed _____

Social Security #: _____ California Driver's License #: _____

Your Employer: _____ Occupation: _____ Years with firm: _____

Employer's Address: _____ City: _____ Zip _____
Street

Spouse's Name: _____

Spouse's Employer: _____ Occupation: _____ Years with firm: _____

Employer's Address: _____ City: _____ Phone: _____
Street

Nearest Relative Not Living with You _____ Home Phone: _____
Name

_____ Work Phone: _____
Street City State Zip

Physician: _____ Date of Last Physical: _____
Name City

Dentist: _____ Years: _____
Name City

Referred By: _____ City: _____ Phone: _____

Who is financially responsible for this bill? _____

FOR PATIENTS WITH DENTAL INSURANCE

Primary Insurance _____	Secondary Insurance _____
Employer _____	Employer _____
Enrollee ID _____	Enrollee ID _____
Group Number _____	Group Number _____
First Name _____	First Name _____
Last Name _____	Last Name _____
Birthdate _____	Birthdate _____

I request and consent to treatment as necessary or desirable to the care of the patient first named above, including any necessary drugs, performance of operations, and laboratory, x-ray, or studies that may be used by the attending doctor or his assistant. Regardless of any estimated insurance coverage, I understand that any fees incurred will be my responsibility. I also certify that the above information is true and accurate.

Signed _____
Signature of Patient or Parent/Guardian if Patient is under 18

MEDICAL AND DENTAL HISTORY

NAME _____

HAVE YOU EVER HAD:	YES	NO
Hepatitis or Liver Disease		
Epilepsy/Seizures		
Rheumatic Fever		
Kidney Disease		
Diabetes		
Tuberculosis		
Heart Trouble		
Damage Heart Valves		
Artificial Heart Valves		
Congenital Heart Lesions		
Coronary Insufficiency		
Coronary Occlusion		
Arterioclerosis		
Stroke		
Cardiac Pacemaker		
Heart Murmur		
High/Low Blood Pressure		
Shortness of Breath		
Thyroid Problems		
Chest Pains		
Allergies		
Medical Treatment by X-ray or Radiation		
Venereal Disease		
Surgery		
Glaucoma		
Prostate Trouble		
Contact Lenses		
Drug Reaction		
Psychiatric Treatment		
Burning Tongue		
Ulcer		
Sinus Problems		
Asthma		
Treatment for a Tumor/ Growth		
Prosthetic Replacement (Hip, Knee, etc.)		
H.I.V. Positive		

An unfavorable Reaction to:		
Aspirin		
Barbiturates		
Anesthetics		
Latex		

An unfavorable Reaction to:	YES	NO
Penicillin		
Sulfa Drugs		
Other_____		

Has a member of your family had Diabetes		

Who?_____

At what age?_____

IF FEMALE, ARE YOU NOW:		
Pregnant		
Taking anti-pregnancy drug		
Presently in Menopause		
Past menopause		

ARE YOU:		
Presently under the care of a physician		
Taking any medication now		
Or within the past year		

Such as:		
Anticoagulants		
Cortisone		
Tranquilizers		
Nitroglycerin		
Penicillin		
Aspirin		
Heart medication		
Medication for high blood pressure		
Bisphosphanates e.g. Fosamax, Zometa		
Other		
_____		
Allergic to dental anesthetic		

Aware of recent weight change		
Subject to frequent urination		
Often thirsty		
Subject to frequent headaches		
Easily exhausted or fatigued		
Slow in healing		
In good health now		
Other_____		
Aware of grinding or clenching your teeth day or night		
Satisfied with the appearance of your teeth		

HAVE YOU:	YES	NO
Ever been told you had gum trouble		
Ever had trench mouth		
Ever been treated for Periodontal Gum Disease by your dentist		
Ever had Orthodontic Treatment		
Had shifting of any teeth		
Ever been told to take antibiotics prior to dental treatment		

DO YOU:		
Ever have sore or popping joints		
Ever have sore teeth		
Ever notice your ankles swell		
Have prolonged bleeding after injury or tooth extraction		
Have a persistent cough or cough up blood		
Get short breath when you lie down or require extra pillows when you sleep		
Have any blood disorder		
Smoke		
_____ Use drugs		
_____ Use alcohol		
Have any other disease or condition I should know about?		
Have any fear of dental treatment		

_____

_____

_____

_____

_____

DOCTOR'S USE ONLY

ASA: I II III IV

_____

Doctor's Signature Date

D.C. FORM 01-1 REV. 10/14

_____

Signature (parent or agent if under 18) Date