PATIENT REGISTRATION

Patient First Name ______ Last Name ______ Middle Initial ______

Address ______

City ______ State ______ Zip Code ______

Sex: ☐ Male ☐ Female Date of Birth ______ Social Security # ______

Home Phone ______ Cell Phone ______ Work Phone ______

DL# ______ Personal Email ______

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Widowed

Spouse Name ______

Preferred contact method: ☐ Email ☐ Phone ☐ Text ☐ Mail

Responsible Party ______

Address (if different from above) ______

City ______ State ______ Zip Code ______

Sex: ☐ Male ☐ Female Date of Birth ______ Social Security # ______

Home Phone ______ Cell Phone ______ Work Phone ______

Primary Insurance Information:

Name of Subscriber ______ Date of Birth ______

Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other

Employer ______ Insurance Carrier ______

Insurance Phone Number ______ Subscriber ID ______ Group # ______

Secondary Insurance Information:

Name of Subscriber ______ Date of Birth ______

Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other

Employer ______ Insurance Carrier ______

Insurance Phone Number ______ Subscriber ID ______ Group # ______

How did you hear about us? ____

Do you have or have had any of the following?

- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Easy Bruising
- ☐ Glaucoma
- ☐ Heard Defect
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Anemia
- ☐ rthritis
- ☐ Cancer
- ☐ Chest Pain
- ☐ Chronic Cough
- ☐ Diabetes
- ☐ Hemophilia
- ☐ igh Blood Pressure
- ☐ Jaundice
- ☐ Nephritis
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sinus Issues
- ☐ Sleep Apnea
- ☐ Tuberculosis
- ☐ Osteoporosis
- ☐ Malignant Hypothermia
- ☐ HIV/AIDS
- ☐ Hepatitis
- ☐ Snoring
- ☐ Pneumonia

Please explain any positive entries above: ______________________________

____

Are there any medical conditions not mentioned above that are part of your medical history? ☐ Yes ☐ No

If yes, please explain: ______________________________

____

What surgeries have you had in the past? ______________________________

____

Any issues with the anesthesia for your surgeries? ☐ Yes ☐ No

Does anyone in your blood relative family have issues with anesthesia? ☐ Yes ☐ No

Have you ever been sedated for a medical or dental procedure? ☐ Yes ☐ No

If yes, were there any complications? ______________________________

____

Do you have a cold? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Do you smoke or vape? ☐ Yes ☐ No

If yes, how many cigarettes per day? ______________

The answers to the following questions will be kept confidential. Please answer them honestly. They are part of your medical record and will not be reported to any law enforcement agencies. Your answers are important as they help us to provide safe anesthesia.

Have you used any of the following during the past year?

☐ Marijuana ☐ MDMA ☐ Heroin ☐ Mushrooms ☐ Meth ☐ Psychedelics ☐ Cocaine ☐ Other ______

If you answered yes to any of the above, when was the last time you used them? ______________________________

Have you suffered from prescription drug abuse of any kind? ☐ Yes ☐ No

If yes, please explain: ______________________________

____

______________________________ Patient Home Dental Office

______________________________ City

______________________________ Name of physician or healthcare provider

______________________________ City

Do you wear braces? ☐ Yes ☐ No

If yes, who is your orthodontist? ______________________________

How did you hear about us? ☐ Facebook ☐ Google ☐ Family/Friend ☐ Dentist/Referral

Who will be the individual responsible for accompanying the patient home?

Name	Relationship	Cell Phone Number
______________	______________	______________

I confirm that all of the above health history information is correct to the best of my knowledge

Patient or Parent Guardian	Signature	Date
______________	______________	______________

OFFICE USE ONLY

Referral ______________	Prior Auth Completed ______________	VDI Completed ______________
Insurance ______________	Prepayment/Deposit Collected ______________	Pano In Record ______________
Medicaid ______________	Consents Signed ______________	