Date: _____

myHealthDentistry

REGISTRATION FORM

PATIENT INFORMATION

Name: _____ Sex: Ma☐ Fem☐

Birthdate: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Telephone: _____
Work Cell Home (Please Circle One)

Preferred Contact Method: Call Text Email (Please Circle One)

Name of Parent or Guardian (Please Circle One): _____

Address if different: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Work Cell Home (Please Circle One)

In Case of emergency, whom shall we notify?

Name: _____ Relationship: _____ Phone: _____

DENTAL INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient: _____

Birthdate: _____ Social Security Number: _____

Name of Employer: _____ Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company City, State, Zip: _____

Group/Policy Number: _____ Subscriber ID: _____

Do you have any additional insurance? ☐ Yes ☐ No If Yes, complete the following:

MEDICAL/DENTAL INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient: _____

Birthdate: _____ Social Security Number: _____

Name of Employer: _____ Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company City, State, Zip: _____

Group/Policy Number: _____ Subscriber ID: _____

myHealthDentistry

DENTAL HISTORY

Reason for Today's Visit: _____

Former Dentist: _____ City/State: _____

Date of Last Dental Visit: _____ Date of Last Dental X-rays: _____

HEALTH HISTORY

Physician's Name: _____

Date of Last Visit: _____ Phone Number: _____

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.

	Yes	No
Have you ever been hospitalized or had a major operation?		
Have you ever had a serious head or neck injury?		
Do you take, or have you taken, Phen-Fen or Redux?		
Have you taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?		
Are you on a special diet?		
Do you use tobacco?		
Do you use controlled substances?		
Do you wear contact lenses?		

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

	Yes	No		Yes	No
AIDS			Herpes		
Alzheimer's Disease			HIV Positive		
Anaphylaxis			Jaundice / Liver Disease		
Anemia			Kidney Disease		
Arthritis, Rheumatism			Nervous Problems		
Artificial Heart Valves			Osteoporosis		
Artificial Joints			Psychiatric Care		

Asthma			Respiratory Disease		
Back Problems			Rheumatic Fever		
Bad Breath / Halitosis			Scarlet Fever		
Abnormal Bleeding			Shortness of Breath		
Blood Disease			Sickle Cell Disease		
Blood Pressure High Low (Please Circle One)			Sinus Trouble		
Blood Transfusion			Jaundice / Liver Disease		
Cancer / Chemotherapy			Skin Rash		
Circulatory Problems			Stroke		
Congenital Heart Lesions			Swelling of Feet		
Cortisone Treatment			Swollen Neck Glands		
Diabetes			Thyroid Problems		
Dry Mouth			Tonsillitis		
Emphysema / Persistent Cough / Bronchitis			Tuberculous		
Epilepsy			Tumor		
Fainting or Dizziness			Ulcer		
Gastritis			Venereal Disease		
Glaucoma			Weight Loss, Unexplained		
Headaches			**Women Only**		
Heart Murmur			Are you pregnant?		
Heart Problems			Are you nursing?		
Hepatitis					

Medications	Allergies
List medications you are currently taking: _____ _____ _____ Pharmacy Name: _____ Phone Number: _____	☐ Aspirin ☐ Barbiturates (Sleeping Pills) ☐ Codeine ☐ Iodine ☐ Latex ☐ Local Anesthetic ☐ Penicillin ☐ Sulfa ☐ Other _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient or Parent _____ Date: _____

Office Use Only

Comments:

_____

_____

_____

Signature of Dentist: _____ Date: _____