Patient Registration and Medical History

Date:_____

Patient Information

Chart# _____

Patient Name_____ SS#_____
Last Name First Name Initial

Address_____

City _____State_____Zip_____

Home (____)_____Cell Phone/Pager(____)_____
(Area code) (Area code)

Sex- M____F____ Age____ Birthdate_____ Single_____ Married_____ Separated_____ Divorced_____

Employer _____Wk# (___)_____Ext._____
(Area Code)

Spouse_____ Contact Phone _____General Dentist_____

In case of emergency, Who should be notified?_____Phone(____)_____
(Area code)

Relationship to patient_____

Have you had prior root canal treatment performed by Dr. Johnson? Yes/No
Have any family members had root canal treatment preformed by Dr. Johnson? Yes/No
If yes, family members name:_____

If different from patient, please fill out information below:

Person responsible for account_____ SS#_____
Relationship to patient_____
Contact Number Home (____)_____ Work(____)_____Ext._____
(Area code) (Area code)

Primary Insurance

Complete this section if covered by Dental Insurance (this information applies to the subscriber who carries the insurance policy)

Name of Insured_____ Date of Birth_____ SS#_____
Employer_____ Work #_____Ext._____

Insurance Co._____ CARD-YES/NO Phone #_____
Address_____
Subscriber ID #_____Group #_____

I hereby authorize the doctor and staff to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions, yet understand whether or not paid by my dental insurance; I am responsible for all charges for treatment.

_____ _____ _____
Signature of patient / responsible party (relationship) Date

(Please Complete Medical History on Reverse Side)

MEDICAL HISTORY

Note: This information is confidential and essential to provide you the best possible care.

Physician's Name (Medical Doctor) _____City_____
Physician's phone number_____
1. Have you been treated by a doctor or been in the hospital in the last 2 years? Yes___ No____ If yes, Why?_____
_____.
2. List Medications you are currently taking:_____
_____.

3. Have you ever taken any of the drugs collectively referred as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phenterminr), Pondimin (fenfluarimine) and Redux (dexfenfluramine) Yes___No___

4. Have you ever had a blood transfusion? Yes___ No ____ If yes, give approximate dates _____
(Women) Are you pregnant? Yes ____ No ___ Nursing? Yes____ No ____ Taking birth control pills? Yes___ No ____

Pre-Medication

5. Has a Doctor or Specialist ever told you that you need to be premedicated with antibiotics prior to dental treatment due to health conditions such as: Heart Murmur/Artificial Joints/Mitral Valve Prolapse? Yes____ No____

6. Have you had, or do you presently have, any of the following conditions? Please check yes or no.

AIDS or HIV Positive	Yes___No___	Hemophilia/Excessive bleeding	Yes___No___
Angina or Chest Pain	Yes___No___	Hepatitis or Liver Disease	Yes___No___
Artificial Heart Valves	Yes___No___	High Blood Pressure	Yes___No___
Artificial Joint	Yes___No___	Kidney Disease	Yes___No___
Asthma	Yes___No___	Low Blood Pressure	Yes___No___
Cancer or Tumors	Yes___No___	Lung Disease	Yes___No___
Congenital Heart Lesions	Yes___No___	Radiation Treatment	Yes___No___
Diabetes	Yes___No___	Rheumatic Fever	Yes___No___
Drug or Alcohol Problem	Yes___No___	Sinus Trouble	Yes___No___
Epilepsy	Yes___No___	Stomach or Intestinal Ulcers	Yes___No___
Heart Attack/Disease/Surgery	Yes___No___	Stroke	Yes___No___
Heart Murmur	Yes___No___	Thyroid Disease	Yes___No___
Heart Pacemaker	Yes___No___	Tuberculosis	Yes___No___

<u>Allergies</u>: Have you ever had an allergic or unusual reaction to any of the following medications?

Aspirin	Yes___No___	Erythromycin or other Antibiotics	Yes___No___
Barbiturates or Tranquilizers	Yes___No___	Latex	Yes___No___
Codeine or other Narcotics	Yes___No___	Penicillin	Yes___No___
Dental Local Anesthetics	Yes___No___	Tylenol	Yes___No___
		Other_____	

The above information is accurate and complete to the best of my knowledge. If changes in my health or medicine occur, I will inform Dr. Johnson prior to treatment. I will not hold my dentist or any member of his/her staff responsible.

Dated:_____ Signature_____
(Patient or Guardian, if patient is a minor)

(Form- R- 2018)