REGISTRATION

Patient's name _____
Last First M.I.

Birth date _____ Age _____ Date _____

❑ Single ❑ Married ❑ Long-Term Partner ❑ Separated ❑ Widowed ❑ Divorced

Name of spouse/partner _____

If a child, parent's name _____

Address _____

City _____ State _____ Zip _____

Business address _____

Telephone: Home _____ Business _____

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 _____

Driver's License No. _____

Spouse/partner's Social Security number _____

Spouse/partner's birth date _____

Name and address of dental insurance company:

Primary _____ Secondary _____

Policy # _____ Policy # _____

Date of last medical examination _____

Do you have 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	____	____

Name of physician_____

Telephone number _____

Are you taking any medication? .....

If so, what _____

_____

Other physical conditions we should be aware of _____

_____

_____

Blood pressure (if known)..... S _____/ D_____ / _____

Signature _____ Date _____

Date	Service Rendered	Charge	Credit	Balance