

PATIENT REGISTRATION MEDICAL AND DENTAL HISTORY

(Please Print)

Date _____ Home / Cellular Phone _____

Patient _____

Last Name First Name Initial Preferred Name

Street Address _____ City _____ State _____ Zip Code _____

E-mail Address _____ Age _____ Date of Birth _____

Social Security # _____ Sex: M _____ F _____

Marital Status: Single _____ Married _____ Widowed _____ Separated _____ Divorced _____

Employed by _____ Occupation _____

Spouse / Parent's Names _____

Spouse / Parent's Employed by _____

Who is responsible for this account? _____ Relationship with Patient _____

Social Security # _____

Name of Dental Insurance Company _____ Group Number _____

In case of emergency, who should be notified? _____ Phone _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical exam. _____

If you have ever had any of the following, please check the boxes that apply with an (X):

<input type="checkbox"/> Heart Problems <input type="checkbox"/> High / Low Blood Pressure <input type="checkbox"/> Circulatory Problems <input type="checkbox"/> Nervous Problems <input type="checkbox"/> Artificial Heart Valves or Joints <input type="checkbox"/> Radiation Treatment <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease <input type="checkbox"/> Back Problems <input type="checkbox"/> Diabetes <input type="checkbox"/> Respiratory Disease <input type="checkbox"/> Epilepsy	<input type="checkbox"/> Headaches <input type="checkbox"/> Swollen Neck Glands <input type="checkbox"/> Cancer <input type="checkbox"/> Chronic Diarrhea <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Allergies <input type="checkbox"/> Blood Disease <input type="checkbox"/> Arthritis <input type="checkbox"/> Special Diet <input type="checkbox"/> Recent Weight Loss <input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Sinus Problems <input type="checkbox"/> HIV / AIDS or Other <input type="checkbox"/> Immunosuppressive <input type="checkbox"/> Disorders <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Stroke <input type="checkbox"/> Ulcer
--	---	---

Do you have any drug allergies or have ever had an adverse reaction to any medication? _____

If so, what? _____

Have you ever responded adversely to medical or dental treatment? _____

Are you taking any medication at this time? _____ If so, what? _____

Are you under the care of a physician? YES _____ NO _____ For what conditions? _____

(Woman) Do you suspect that you are pregnant? YES _____ NO _____ Are you nursing? YES _____ NO _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his / her staff responsible for any errors or omissions that I may have made in the completion of this form.

DATE _____

SIGNATURE _____

Gemini Dental