PATIENT REGISTRATION
MEDICAL AND DENTAL HISTORY

(Please Print)

Date ____Home / Cellular Phone ____

Patient ____

Last Name First Name Initial Preferred Name

Street Address __________________________________City _________________State __________ Postal Code ____________

E-mail Address ____ Age __________ Date of Birth ____________________

Health Card # ____ 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 _______________

Health Card # ____

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):

- [ ] Heart Problems
- [ ] High/Low Blood Pressure
- [ ] Circulatory Problems
- [ ] Nervous Problems
- [ ] Artificial Heart Valves or Joints
- [ ] Radiation Treatment
- [ ] Hepatitis, Jaundice or Liver Disease
- [ ] Back Problems
- [ ] Diabetes
- [ ] Respiratory Disease
- [ ] Epilepsy
- [ ] Headache
- [ ] Swollen Neck Glands
- [ ] Cancer
- [ ] Chronic Diarrhea
- [ ] Psychiatric Care
- [ ] Allergies
- [ ] Blood Disease
- [ ] Arthritis
- [ ] Specialist Diet
- [ ] Recent Weight Loss
- [ ] Rheumatic Fever
- [ ] Sinus Problems
- [ ] HIV/AIDS or Other
- [ ] Inmunosuppressive
- [ ] Disorders
- [ ] Thyroid Problems
- [ ] Stroke
- [ ] 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: ___________________________

Stevenson Dental Care