

Patient Registration

Patient Information

Patient _____
Last Name First Middle

Home Address _____
Street City State Zip

Birth Date	Sex	Weight	Age
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Hm. Phone: () - _____
 Wk. Phone: () - _____
 Mobile Phone: () - _____

Employer _____ Occupation _____

Social Security Number _____ - - - Student Full Time Part Time

Nearest Relative / Roommate living at the same address: _____

Financially Responsible Party

Person responsible for bill _____ Relationship _____
Street City State Zip

Hm. Phone: () - _____
 Wk. Phone: () - _____
 Mobile Phone: () - _____

Responsible Party's SS# _____ - - -

PRIMARY Insurance Company _____ Employer _____
Primary Insurance Address City State Zip Phone

Policy Holder _____ DOB _____ ID# _____ Group# _____

SECONDARY Insurance Company _____ Employer _____
Secondary Insurance Address City State Zip Phone

Policy Holder _____ DOB _____ ID# _____ Group# _____

Patient Physical History

1. Have you been a hospital patient within the past 5 years? Yes No
 If so, for what? _____

2. Are you presently under a physician's care for any reason? Yes No
 If so, why? _____

3. Name any medications you are taking: _____

4. Have you had any of the following?

<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Sinus Difficulty
<input type="checkbox"/> Asthma	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chronic Cough
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Nephritis	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Anemia
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Seizures	<input type="checkbox"/> Stroke	<input type="checkbox"/> Glaucoma
		<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> HIV-AIDS

5. Are you allergic to any of the following?

<input type="checkbox"/> Novocaine	<input type="checkbox"/> Pentothal	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Aspirin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Other Medications	<input type="checkbox"/> Demerol	<input type="checkbox"/> Sedatives
<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Lortab	<input type="checkbox"/> Other: _____	

6. Have you had any other serious illness requiring doctors care? Yes No

7. Have you had a recent cough or cold? Yes No

8. Do you smoke? Yes No

9. Are you pregnant? (Women) Yes No
 If so, how many per day? _____

10. What is the name of your family dentist? _____ City where office is located? _____

11. Family/Personal Physician's Name: _____ City where office is located? _____

12. How did you find out about our practice? _____