Patient Registration

Patient Information:

Name: _____ Preferred Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone Number: Home: _____ Cell: _____ Work: _____

Date of Birth: _____ Gender: __M__F Social Security #: _____ Marital Status: _____

Email address: _____

Employer Information:

Name of Company: _____ Phone Number: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Responsible Party (if different from above):

Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone Number: Home: _____ Cell: _____ Work: _____

Social Security #: _____ Relationship to patient: _____

Insurance Information:

Insurance: _____ Subscriber ID#: _____ Group#: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Gender: __M__F Social Security #: _____

Relationship to the Patient: _____

Emergency Contact: _____ Phone #: _____

Health Information: Name of Physician: _____ Phone Number: _____

☐ Heart Problems	☐ History of Cancer	☐ Arthritis	☐ General Allergies
☐ Heart Murmur	☐ Radiation Treatment	☐ Sinus Problems	☐ Chemical Dependency
☐ Artificial Valve/Joints	☐ Hepatitis Type	☐ Stroke	
☐ Epilepsy/Seizures	☐ Liver Disease	☐ High Blood Pressure	
☐ Diabetes	☐ Kidney Disease	☐ Low Blood Pressure	
☐ Respiratory Disease	☐ Tobacco Use	☐ Allergies to Anesthetics	

Are you pregnant?_____ If so, how many weeks?_____

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

If yes, what?_____

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

Are you under the care of a physician? __Y__N If yes, for what treatment? _____

Are you taking any medication at this time? __Y__N If yes, please list_____

Is there any other information we should know about your medical history?_____