# Patient Registration

What is the reason for your visit today?_____ Referred by? _____
Patient Name _____ DOB_____ SS#_____
Home Address_____
E-Mail_____ Home #_____ Cell #_____

## HEALTH INFORMATION

| PLEASE REVIEW CAREFULLY | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Recent hospitalization (within 1 year) | | | Hepatitis (Type ) | | |
| Any allergies? (write in below) | | | Gastric acid reflux (GERD) | | |
| Heart attack | | | Emphysema | | |
| History of infective endocarditis | | | Asthma | | |
| Artificial heart valve, repaired defect | | | Sleep Apnea or sleep disorders | | |
| Cardiac transplant | | | Thyroid Disease | | |
| Congenital (birth) heart conditions | | | Acute angle glaucoma | | |
| Any joint replacement within 2 years | | | Alcohol/drug dependency | | |
| High or low blood pressure | | | Epilepsy, convulsions (seizures) | | |
| Taking blood thinners | | | Antidepressant medication | | |
| Prolonged bleeding due to a cut | | | Viral cold sores or canker sores | | |
| Anemia or other blood disorder | | | Any lumps or swelling in the mouth | | |
| Angina | | | **Describe any medical treatment, impending surgery** | | |
| Stroke | | | **And list of medication(s) you are taking:** | | |
| Medication for osteoporosis or osteopenia? (Boniva, Prolia, Zometa, Fosamax, Xgeva, Denosumab) | | | | | |
| Use any tobacco products | | | | | |
| Diabetes | | | | | |
| HIV/AIDS | | | | | |
| Radiation therapy (current or past) | | | **NOTES:** | | |
| Currently having chemotherapy | | | | | |
| Tuberculosis | | | | | |
| Liver disease | | | | | |
| Kidney disease (having dialysis?) | | | | | |
| FEMALE-pregnant | | | | | |
| FEMALE-taking birth control pills | | | | | |

I authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for balances and authorize the office to release (information for my claim(s). I authorize that my records can be used by the doctor if he so determines. I certify I have read or had read to me this form.

I acknowledge the offices "Notices of Privacy Practices" (posted in reception). Please list anyone authorized for us to share your protected health information above.

**Patient's Signature**_____ Date_____ Dr.Sig_____