Patient Registration

Name_____ Date of Birth_____

Primary Phone (H/C/W)_____ Secondary Phone (H/C/W)_____

Mailing Address_____ Street Address_____

City_____ State_____ Zip_____

Social Security #_____Pharmacy/Location_____/_____

Dental Insurance (Primary)_____	Dental Ins. (Secondary)_____
Subscriber name:_____	Subscriber name:_____
Subscriber DOB:_____	Subscriber DOB:_____
Subscriber ID:_____	Subscriber ID:_____

Responsible Party (if patient is a minor)_____

Email Address_____

Patient Employed by_____ Present Position_____

Business address_____

Spouse/Parent Name_____ Spouse/Parent DOB_____

Spouse/Parent Employed By_____

REFERRED BY_____ GENERAL DENTIST_____

MEDICAL HISTORY

Do you have or have you ever had:

	Yes	No
Heart Disease		
Heart murmur or MVP	☐	☐
Heart Attack	☐	☐
Rheumatic fever	☐	☐
Pace Maker	☐	☐
Chest pain	☐	☐
Palpitation	☐	☐
Shortness of breath	☐	☐
High blood pressure	☐	☐
Lung Disease		
Asthma	☐	☐
Emphysema	☐	☐
Chronic cough	☐	☐
Sinus Trouble	☐	☐
Hepatitis	☐	☐
HIV Virus	☐	☐
Joint Hip Replacement	☐	☐

	Yes	No
Thyroid Disease	☐	☐
Liver Disease	☐	☐
Kidney Disease	☐	☐
Diabetes	☐	☐
Anemia	☐	☐
Bleeding problems	☐	☐
Ulcers	☐	☐
Mental illness	☐	☐
Epilepsy/seizures	☐	☐
Fainting spells	☐	☐
Immuno suppressive disease	☐	☐

CURRENT MEDICATIONS: List

MEDICATIONS:

	Yes	No
Steroids	☐	☐
Anticoagulants	☐	☐
High Blood Pressure	☐	☐
Heart Medications	☐	☐
Bone Density	☐	☐
Tranquilizers	☐	☐
Antidepressants	☐	☐
Birth Control Pills	☐	☐
Ibuprofen **Today**	☐	☐
Latex Allergy	☐	☐
Penicillin Allergy	☐	☐

DRUG ALLERGIES: List

Women: Are you pregnant? Yes ☐ No ☐

Have you had any serious illnesses or injuries? Please Explain. Yes ☐ No ☐

_____

_____

Do you need to be pre-medicated before dental treatment due to heart problems or joint replacement? Yes ☐ No ☐

Have you been under the care of a physician in the past five years? Yes ☐ No ☐

_____

I attest that the above information is true and correct and I understand that I am personally responsible for payment of all services rendered in this office.

Signature _____ **Date:** _____

_____

Doctor's Signature

CAPE COD ENDODONTICS