Patient Registration Update Today's Date_____

Patient Name_____ Date of Birth_____

Current Address_____City_____State_____Zip_____

Best Phone #_____ E-mail address_____

Dental Insurance Carrier(s)_____

Person responsible for patient account_____

Emergency Contact (name & phone # of nearest relative)_____

MEDICAL HISTORY (circle all that apply)

AIDS	HIV Positive	Emphysema	Stomach Problems
Alleriges (seasonal)	HPV	Epilepsy	Stroke
Anemia	Jaundice	Excessive Bleeding	Thyroid Disease
Angina (chest pain)	Jaw Joint Pain	Fainting	Tuberculosis
Arthritis	Kidney Disease	Glaucoma	Ulcers
Artificial Heart Valve	Liver Disease	Heart Conditions	Venereal Disease
Artificial Joints	Low Blood Pressure	Heart Lesions (congenital)	Other_____
Asthma	Mitral Valve Prolapse	Heart Murmur	_____
Bruise Easily	Nervousness/Depression	Heart Surgery	_____
Cancer	Pacemaker	Hepatitis A	_____
Cervical Cancer	Pregnant Currently	Hepatitis B	
Chemotherapy	Radiation	Hepatitis C	
Cortisone Medication	Respiratory Problems	High Blood Pressure	
Diabetes	Rheumatic Fever	Seizures	
Dizziness	Rheumatism	Sinus Problems	
Drug Addiction	Scarlet Fever	Sleep Apnea	

Are you allergic or have you reacted adversely to any of the following medications?

Aspirin	Percoden	Tetracycline	Valium
Amoxicillin	Darvon	Latex	Codeine
Penicillin	Nitrous Oxide	Local Anesthetic	Erythromycin
Sulfa	Other_____		

Please list current medications_____
_____
Are you under a physician's care? What for?_____
_____

Family physician_____ Phone Number_____

Consent:
The undersigned herby authorizes Doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

Patient Signature (parent if child)_____ Date_____

_____NO CHANGES

Doctor Signature_____