Watsontown Dental P.C. # PATIENT REGISTRATION AND MEDICAL HISTORY

Date______________________ (please print) Preferred Phone (____) __________________________

Patient____
Last Name First Name Middle Initial Preferred Name

Street Address ___________________________ City ________________ State ________ Zip __________

E-mail ____ Cell Phone (___) ____________________________

Sex___M____F Age____ Birthdate______________ ____Single _____Married____Widowed___Separated____Divorced

Pharmacy of Choice____Town_________________________________

Patient Employer/School ______________________________ Spouse/Parent Employer______________________________

Patient Employer/School Address ________________________ Spouse/Parent Employer Phone ________________________

Patient Occupation ___________________________________ Spouse/Parent Birthdate ____________________________

Patient Social Security# _______________________________ Spouse/Parent Occupation___________________________

Business Phone____________________________________ Business Phone (___)__________________________

Who is the guarantor of this account? ____________________ Relationship to Patient __________________________

Dental Insurance Com_______________________________ Spouse/Parent's Social Security # _______________

Dental Insurance ID #_________________________ Group Number ____________________________

In case of emergency, who should we notify? ___________________ Phone (____) ___________________

Whom may we thank for referring you? ____

Medical History

Physician's Name ___________________________________ Physician's Phone Number___________________

Have you ever had any of the following? (check all that apply)

____Abnormal bleeding
____Alcohol abuse
____Allergies
____Arthritis
____Artificial Heart Valve
____Artificial Joints
____Cancer
____Chemotherapy
____Cold Sores
____Dementia
____Diabetes
____Dialysis
____Difficulty breathing
____Drug Abuse

____ Epilepsy
____ Fainting spells
____ Heart murmur
____ Heart Disease
____ Hepatitis A,B,C,D
____ High/Low Blood Pressure
____ HIV/AIDS
____ Infusion Treatments
____ Kidney Disease
____ Liver Disease
____Migraines
____ Mitral valve prolapse
____Multiple Sclerosis
____Neurological Disorders

____Pacemaker
____Parkinson’s Disease
____Psychiatric Problems
____Radiation Therapy
____Reflux
____Respiratory Illness
_____Sinus Problems
_____Seizures
_____Stroke
____TMJ Disorder
____Thyroid Problems
____Tobacco Use
_____Tuberculosis
_____Ulcers

Do you have any drug allergies or ever had an adverse reaction to any medication or anesthesia? ___ Yes ___ No

If so, what? ____

Have you ever responded adversely to medical or dental treatment? ____ Yes ____ No Latex Allergy ____ Yes_____No

Are you taking any medication at this time? _______ If so, what? ____

Are you under the care of a physician? ____ If so, for what conditions? _____________________________________

Date of your last physical ________________If patient is a child, what is his/her weight____________________________

Have you been in the hospital the past year? ____Yes___No If yes, for what?___________________________________

(Women) Do you suspect that you are pregnant? ___Yes ___ No Due Date _____________________________________
(Women) Are you nursing? ____ Yes ____ No Taking Birth Control Pills _____ Yes ____ No

Have you traveled outside the country in the last 3 months? ___Yes____No If yes, where?________________________

____
Signature of Parent, Guardian or Personal Representative **Date**

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Please Print Name of Parent, Guardian or Personal Representative **Relationship to Patient**