MR.
MRS.
MISS

REGISTRATION

DATE

DATE OF BIRTH

S M W D

HOME ADDRESS

HOME PHONE

CITY

STATE

ZIP CODE

E-MAIL

CELL PHONE

SS#/SIN

EMPLOYER

ADDRESS

OCCUPATION

BUS.

PREVIOUS ADDRESS

TEL.

PERSON RESPONSIBLE FOR ACCOUNT

CITY

STATE

ADDRESS

REFERRED BY

PHYSICIAN

DENTAL INSURANCE PROGRAM

LOCAL NO.

PURPOSE OF CALL

PREFERRED DAY FOR APPTS.

TIME

AM
PM

REMARKS

MEDICAL HISTORY

1. Are you in good health? _____
2. Are you under a physician's care now? _____ If so, please give reason for treatment.
   _____
3. Are you taking any kind of medication at this time? _____
4. Have you ever taken Fen-Phen/Redux? _____
5. Please circle any illnesses you have ever had:

allergies	tuberculosis	anemia	kidney or liver	other
rheumatic fever	diabetes	heart trouble	asthma	
infectious hepatitis	epilepsy	glaucoma	HIV infection	

6. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? _____
7. Have you ever had trouble with prolonged bleeding after surgery? _____
8. Have you ever had any unusual reaction to an anesthetic or drug (like penicillin)?
   _____
9. Is there any other information that should be known
   about your health? _____
   about previous dental visits? _____

_____

Signature