



# PATIENT REGISTRATION

\_\_\_\_\_  
Patient First Name Last Name Middle Initial

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip Code

Sex:  Male  Female Date of Birth Social Security #

\_\_\_\_\_  
Home Phone Cell Phone Work Phone

\_\_\_\_\_  
DL# Personal Email

Marital Status:  Married  Single  Separated  Widowed

\_\_\_\_\_  
Spouse Name

Preferred contact method:  Email  Phone  Text  Mail

### Responsible Party

\_\_\_\_\_  
Address (if different from above)

\_\_\_\_\_  
City State Zip Code

Sex:  Male  Female Date of Birth Social Security #

\_\_\_\_\_  
Home Phone Cell Phone Work Phone

### Primary Insurance Information:

\_\_\_\_\_  
Name of Subscriber Date of Birth

Relationship:  Self  Spouse  Child  Other

\_\_\_\_\_  
Employer Insurance Carrier

\_\_\_\_\_  
Insurance Phone Number Subscriber ID Group #

### Secondary Insurance Information:

\_\_\_\_\_  
Name of Subscriber Date of Birth

Relationship:  Self  Spouse  Child  Other

\_\_\_\_\_  
Employer Insurance Carrier

\_\_\_\_\_  
Insurance Phone Number Subscriber ID Group #

How did you hear about us? \_\_\_\_\_

Do you have or have had any of the following?

- Emphysema       Heart Murmur       Diabetes       Seizures       HIV/AIDS
- Excessive Bleeding       Anemia       Hemophilia       Sinus Issues       Hepatitis
- Easy Bruising       Arthritis       High Blood Pressure       Sleep Apnea       Snoring
- Iaucoma       Cancer       Jaundice       Tuberculosis       Pneumonia
- Heard Defect       Chest Pain       Nephritis       Osteoporosis
- Heart Disease       Chronic Cough       Rheumatic Fever       Malignant Hypothermia

Please explain any positive entries above: \_\_\_\_\_

Are there any medical conditions not mentioned above that are part of your medical history?       Yes       No

If yes, please explain: \_\_\_\_\_

What surgeries have you had in the past? \_\_\_\_\_

Any issues with the anesthesia for your surgeries?       Yes       No

Does anyone in your blood relative family have issues with anesthesia?       Yes       No

Have you ever been sedated for a medical or dental procedure?       Yes       No

If yes, were there any complications? \_\_\_\_\_

Do you have a cold?       Yes       No

Are you pregnant?       Yes       No

Do you smoke or vape?       Yes       No

If yes, how many cigarettes per day? \_\_\_\_\_

**The answers to the following questions will be kept confidential. Please answer them honestly. They are part of your medical record and will not be reported to any law enforcement agencies. Your answers are important as they help us to provide safe anesthesia.**

Have you used any of the following during the past year?

- Marijuana       MDMA       Heroin       Mushrooms       Meth       Psychedelics       Cocaine       Other

If you answered yes to any of the above, when was the last time you used them? \_\_\_\_\_

Have you suffered from prescription drug abuse of any kind?       Yes       No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
Patient Home Dental Office

\_\_\_\_\_  
City

\_\_\_\_\_  
Name of physician or healthcare provider

\_\_\_\_\_  
City

Do you wear braces?       Yes       No      If yes, who is your orthodontist? \_\_\_\_\_

How did you hear about us?       Facebook       Google       Family/Friend       Dentist/Referral

Who will be the individual responsible for accompanying the patient home?

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Cell Phone Number

I confirm that all of the above health history information is correct to the best of my knowledge

\_\_\_\_\_  
Patient or Parent Guardian

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**OFFICE USE ONLY**

- Referral \_\_\_\_\_      Prior Auth Completed \_\_\_\_\_      VDI Completed \_\_\_\_\_
- Insurance \_\_\_\_\_      Prepayment/Deposit Collected \_\_\_\_\_      Pano In Record \_\_\_\_\_
- Medicaid \_\_\_\_\_      Consents Signed \_\_\_\_\_