Skutak Dental, S. C.

PATIENT REGISTRATION FORM

Patient Information

Name: _____

☐ Male ☐ Female

☐ Single ☐ Married ☐ Minor

Birth Date: _____

Social Security #: _____

Phone (Home): _____

(Work): _____ Ext _____

(Cell): _____

Emergency Contact: _____

Relationship: _____

Daytime Phone: _____

Referral Information

Whom may we thank for referring you to our practice?

☐ Another patient, Name: _____

☐ Yellow Pages ☐ Newspaper

☐ Other: _____

Insurance Information

Subscriber Name: _____ DOB: _____

Relationship to Patient: _____ ID: _____

Insurance Company: _____

**I authorize my insurance company to pay Skutak Dental directly for any treatment:

Health Information

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Asthma
- ☐ Bad Breath
- ☐ Blood Disease
- ☐ Cancer/Chemo.
- ☐ Chemical Dep.
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Diabetes
- ☐ Psychiatric Care
- ☐ Bleeding
- ☐ Respiratory Problems
- ☐ Headaches
- ☐ Rheumatism/Arthritis
- ☐ Heart Murmur
- ☐ Hepatitis, type __
- ☐ High/Low Blood Pressure
- ☐ Jaw Pain
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Clicking/Pop. Jaw
- ☐ Cortisone Treatments
- ☐ Congenital Heart Def.
- ☐ Cortisone Treatments
- ☐ Pregnancy, Due: ___
- ☐ Epilepsy
- ☐ Radiation Treatment
- ☐ Grinding/Clenching
- ☐ Rheumatic/Scarlet Fever
- ☐ Sensitive Teeth
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Swollen Feet/Ankles
- ☐ Tobacco Use/Smoking
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker/Defibrillator
- ☐ Periodontal/Gum Disease
- ☐ Emphysema
- ☐ Prosthetic Heart Valve Excessive
- ☐ Fainting/Dizziness
- ☐ Rheumatic Heart Disease
- ☐ Heart Disease

Current Medications

Please list current medications:

_____

_____

_____

_____

Allergies

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Latex
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other _____

_____

_____

Sign: _____

Date: _____

Office Use Only