

PATIENT REGISTRATION

ID: _____

Chart ID: _____

First Name: _____

Last Name: _____

Middle Initial: _____

Patient Is: Policy Holder Responsible Party

Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____

Last Name: _____

Middle Initial: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Pager: _____

Home Phone: _____

Work Phone: _____

Ext: _____

Cellular: _____

Birth Date: _____

Soc Sec: _____

Drivers Lic: _____

Responsible Party is also a Policy Holder for Patient

Primary Insurance Policy Holder

Secondary Insurance Policy Holder

Patient Information

Address: _____

Address 2: _____

City: _____

State / Zip: _____

Pager: _____

Home Phone: _____

Work Phone: _____

Ext: _____

Cellular: _____

Sex: Male Female

Marital Status: Married Single

Divorced

Separated

Widowed

Birth Date: _____

Age: _____

Soc Sec: _____

Drivers Lic: _____

E-mail: _____ I would like to receive correspondences via e-mail.

Section 2

Section 3

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Medicaid ID: _____

Prof. Dentist: _____

Employer ID: _____

Prof. Pharmacy: _____

Carrier ID: _____

Prof. Hyg: _____

Referred By _____

Previous Dentist _____

Emergency Contact _____

Emergency Contact # _____

Ins Effective Date _____

Primary Insurance Information

Name of Insured: _____

Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____

Insured Birth Date: _____

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

Address 2: _____

Address 2: _____

City, State, Zip: _____

City, State, Zip: _____

Rem. Benefits: _____

Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____

Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____

Insured Birth Date: _____

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

Address 2: _____

Address 2: _____

City, State, Zip: _____

City, State, Zip: _____

Rem. Benefits: _____

Rem. Deduct: _____

Capital City Periodontics Medical History (6/04/19 updated)

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Have you ever been hospitalized or had a major operation? Date of last physical exam? Have you ever had a serious head or neck injury? Have you ever taken Fosamax, Boniva, Actonel or any other medication or had an injection for bone density? Are you taking any additional prescription or over the counter medications (including supplements and vitamins)? Are you taking any anticoagulants/blood thinners (including aspirin)? Do you take, or have you taken any dietary supplements? Do you use any type of tobacco product? If yes, please indicate frequency. Do you use controlled substances? Has your doctor stated that you need to pre-medicate with antibiotics before dental visits? If yes, indicate reason. Have you been diagnosed with or treated for sleep apnea?

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin NSAIDS Codeine Penicillin Latex Metal

Other Allergies? If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive Alzheimer's Disease Anaphylaxis Anemia Angina Arthritis Artificial / Prosthetic Joint Artificial/Damaged Heart Valve Asthma Bleeding disorders Blood Transfusion Breathing Problems Bruise Easily Cancer Chemotherapy Chest Pains Cold Sores/Fever Blisters Congenital Heart Disorder Convulsions Cortisone Medicine Diabetes or high glucose Drug Addiction Easily Winded Emphysema Epilepsy or Seizures Excessive Bleeding Excessive Thirst Fainting Spells/Dizziness Frequent Cough Frequent Diarrhea Frequent Headaches Glaucoma Heart Attack/Failure Heart Murmur Heart Pacemaker Heart Trouble/Disease Hemophilia Hepatitis A Hepatitis B or C Herpes High Blood Pressure High Cholesterol Hives or Rash Hypoglycemia Irregular Heartbeat Jaundice Kidney Problems Leukemia Liver Dysfunction Low Blood Pressure Low Immune Function Lung Disease Mitral Valve Prolapse Osteoporosis Pain in Jaw Joints Parathyroid Disease Psychiatric Care Radiation Treatments Renal Dialysis Rheumatic Fever Rheumatism Scarlet Fever Shingles Sickle Cell Disease Sinus Problems Spina Bifida Stomach/Intestinal Disease Stroke Swelling of Limbs Thyroid Disease Tonsillitis Tuberculosis Tumors or Growths Ulcers or Gastrointestinal problems Venereal Disease

Have you ever had any serious illness not listed above? If yes

Do you require specific accommodations?

[Empty text box for accommodations]

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____

Date: _____