

PATIENT REGISTRATION FORM

Please print

PERSONAL INFORMATION: E-mail: _____ **Date** _____

Name _____ **Birth Date** _____ **Sex** _____
 First M.I. Last

Address _____
 Street Address Apt# City State Zip

Phone: (Day) _____ **(Eve)** _____ **(Cell)** _____
 Area code Number Area code Number Area code Number

in house hold _____ **Marital Status** _____ **Race** _____ **Education** _____

Spouse/Sig. Other _____ **Closest Relative or Friend** _____
 Name Phone Name Phone

Employer _____ **Phone** _____ **Occupation** _____
(patient or parent)

Referred by _____ **Responsible party (if minor)** _____

Allergies _____

Chief Complaint _____

FAMILY HISTORY: If any blood relative has suffered any of the following, please indicate which relative.

Allergies _____ **Asthma** _____ **Anemia** _____ **Arthritis** _____ **Alcoholism** _____

Blood Clotting Problems _____ **Cancer** _____ **Diabetes** _____ **Epilepsy** _____

Glaucoma _____ **Genetic Disease** _____ **Gout** _____ **Headaches** _____

Heart Disease _____ **High Blood Pressure** _____ **Kidney/Bladder Problem** _____

Mental Illness _____ **Stroke** _____ **Tuberculosis** _____ **Other** _____

DENTAL HISTORY:

Extractions () no () yes # of teeth _____ **Root Canals** () no () yes **Implants** () no () yes

Bridges () no () yes [() upper () lower] **Does any bridge cross the midline?** () no () yes

Dentures () upper () lower () partial **Age last fitted** _____

Do you currently or did you have: () overbite () under bite () crooked teeth () buck teeth

Orthodontia () no () yes, age _____ **Reason for orthodontia:** _____

Temporomandibular Joint (TMJ): splints () no () yes [() upper () lower]

surgery () no () yes [() left () right]

Health Habits(place a check for the substances you use and amount)

- () Caffeine _____
- () Tobacco _____
- () Drugs _____
- () Water _____
- () Alcohol _____
- () Chocolate _____
- () Sugar _____
- () Other _____

Occupational Concerns

- () Stress _____
- () Hazardous substance _____
- () Heavy Lifting _____
- () Other _____

Diet: Breakfast _____ Lunch _____

Dinner _____ Snacks _____

Exercise: Type & Frequency

CONDITIONS Check those which you have or have had in the past:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug dependent | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Measles | <input type="checkbox"/> STD's |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraines | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Suicide thoughts |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breast lump | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Polio | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Prostate problem | <input type="checkbox"/> Unconsciousness |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Post-partum Blues | <input type="checkbox"/> Vaginal infections |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Coma | <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Rheumatic fever | |

Serious Injuries, Fractures or Illnesses. Hospitalizations or Surgeries.

Event	Date	Outcome
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Medications(dose and frequency)

Childbirth History(year, sex, and complication)

Other procedures-items (yes or no and dates):

Last physical exam:

Last eye exam:

Cosmetic surgery-Face lift:

Botox:

Collagen:

Steroid injections:

Colonoscopy – Sigmoidoscopy:

Colon Hydro Therapy:

Chiropractic care:

Cranial Sacral care:

Acupuncture:

Rolfing or Massage:

Women only:

Last pap and mammogram:

Breast augmentation: