Print Form

PATIENT REGISTRATION AND MEDICAL HISTORY

Welcome to Simon Dental Care. We strive to provide you with the best possible dental acre.
To help us meet your dental needs, please fill out this form completely

NAME _____
(LAST) (FIRST) (M.I.) (PREFERRED NAME)

ADDRESS_____ CITY/STATE_____ ZIP_____

HOME PHONE_( )_____ CELL PHONE ( )_____ EMERGENCY CONT.( )_____

E-MAIL _____ SS# _____

(Patient communication only, never disclose your e-mail to anyone.)

SEX ☐M ☐F BIRTH DATE_____ ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED

IF STUDENT, NAME OF SCHOOL/COLLEGE_____ ☐ FULL TIME ☐ PART TIME

EMPLOYED BY_____ DENTAL INSURANCE: ☐ YES ☐ NO

SPOUSE / PARENT NAME (if minor)_____

HOW DID YOU HEAR ABOUT US?_____

MEDICAL HISTORY

NAME OF PHYSICIAN:_____ LAST PHYSICAL: _____

HAVE YOU BEEN UNDER A PHYSICIAN'S CARE DURING THE PAST 2 YEARS?_____ FOR:_____

HAVE YOU BEEN TREATED IN A HOSPITAL IN THE PAST 2 YEARS?_____ FOR:_____

DO YOU USE TOBACCO? ☐ YES ☐ NO ARE YOU WEARING CONTACT LENSES? ☐ YES ☐ NO

WOMEN(please check): ☐ PREGNANT/TRYING TO GET PREGNANT ☐ NURSING ☐ TAKING ORAL CONTRACEPTIVES

HAVE YOU EVER HAD A BLOOD TEST FOR HEPATITIS?_____ HAD HEPATITIS_____ VACCINATION?_____

HAVE YOU HAD CANKER OR COLD SORES ON YOUR LIPS, TONGUE, GUMS OR BODY?_____

ARE YOU ALLERGIC TO ANY MEDICATIONS OR SUBSTANCES? ☐ YES or ☐ NO PLEASE CHECK BOXES BELOW.

☐ASPIRIN ☐ PENICILLIN/OTHER ANTIBIOTIC ☐CODEINE ☐ACRYLIC ☐ LATEX RUBBER ☐ ANESTHETICS ☐ JEWELRY/METAL

OTHER:_____

ARE YOU TAKING MEDICATIONS NOW? ☐Y ☐N FOR WHAT PURPOSE:_____

LIST MEDICATIONS: _____

DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK THE APPROPRIATE BOXES.

YES	NO		YES	NO		YES	NO	
☐	☐	AIDS	☐	☐	DIABETES	☐	☐	POLIO
☐	☐	ANEMIA	☐	☐	DRUG/ALCOHOL DEPENDENCY	☐	☐	PROLONGED BLEEDING
☐	☐	ANGINA/CHEST PAIN	☐	☐	FAINTING OR DIZZINESS	☐	☐	PROLONGED COUGH
☐	☐	ARTHRITIS/GOUT	☐	☐	GLAUCOMA	☐	☐	PSYCHIATRIC CARE
☐	☐	ARTIFICAL HEART VALVE	☐	☐	HEART ATTACK/FAILURE	☐	☐	RADIATION THERAPY/CHEMO
☐	☐	ARTIFICIAL JOINTS	☐	☐	HEART MURMUR	☐	☐	RHEUMATIC FEVER
☐	☐	ASTHMA	☐	☐	HEPATITIS/JAUNDICE	☐	☐	SEXUALLY TRAMSITTED DISEASE
☐	☐	BLOOD PRESSURE (High/Low)	☐	☐	KIDNEY PROBLEMS	☐	☐	THYROID DISEAS
☐	☐	CANCER	☐	☐	LIVER DISEASE	☐	☐	TUBERCULOSIS
☐	☐	COLD SORE	☐	☐	ORGAN TRANSPLANT	☐	☐	ULCERS

HAVE YOU HAD ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE?_____

AUTHORIZATION

I certify that the foregoing information is true and correct. I authorize Simon Dental Care to release information regarding my dental history or X-Rays needed for future treatment to dental insurance carrier. I hereby authorize my dental insurance carrier to make payment directly to Simon Dental Care otherwise payable to me. I understand that my health insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

DATE_____ PATIENT (or Parent) SIGNATURE_____

(PLEASE COMPELETE NEXT PAGE)