PATIENT REGISTRATION AND MEDICAL HISTORY

(PLEASE PRINT)

Date ___________

PATIENT INFORMATION

Business Phone Number _______________

Name ____ Home Phone Number ______________________

Street Address _________________________ City ____________________ State _____ Zip _________

Sex Male Female

Marital Status ____________________________

Birthdate ________________

Social Security Number ______/_____/_____

Dentist Name ___________________________

Whom may we thank for referring you? ________________________________

RESPONSIBLE PARTY INFORMATION (if different than above)

Name ____ Social Security Number ______/_____/_____

Employer ____________________________________ Occupation ____________________________

Business Address ______________________________ Business Phone ______________________

Relationship to patient ___________________________ Birthdate ____________________________

In case of emergency, contact (name, phone) ____

DENTAL INSURANCE INFORMATION

Dental Insurance Company ________________________ Group Number ______________________

Insurance Co. Phone Number ______________________

Name of Insured ______________________________ Social Security Number ______/_____/_____

MEDICAL HISTORY

Physician's Name ______________________________ Date of Last Physical ______________________

Have you ever had any of the following? (check boxes that apply):

AIDS or other Immunosuppressive Disorders	Circulatory Problems	Psychiatric Care
	Diabetes	Radiation Treatment
Allergies to Anesthetics	Epilepsy	Recent Weight Loss
Allergies to Medicine or Drugs	General Allergies	Respiratory Disease
Arthritis	Headaches	Rheumatic Fever
Artificial Heart Valves or Joints	Heart Problems	Sinus Problems
Back Problems	Hepatitis, Jaundice or Liver Disease	Special Diet
Blood Disease	Hemophilia	Stroke
Cancer	High Blood Pressure	Swollen Neck Glands
Chemical Dependency	Low Blood Pressure	Ulcer
Chronic Diarrhea	Nervous Problems	Venereal Disease

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____________

If so, what? ____

Have you ever responded adversely to medical or dental treatment? ______________________________

Are you taking any medication at this time? _____ If so, what? _______________________________

Are you under the care of a physician? Yes No

For what conditions? ____

(Women) Do you suspect that you are pregnant? Yes No Are you nursing? Yes No

Is there anything else we should know about your medical history? ____________________________

The above information is accurate and complete to the best of my knowledge and is for use in treatment, billing and to obtain my credit history in order to arrange for payment terms. I will not hold Dr. Warshawsky or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form. I give Dr. Warshawsky and his associates permission to use all diagnostic records for teaching and/or learning purposes. All names and identifications will be withheld for such purposes.

Date ______________________ Signature ____