PATIENT REGISTRATION

DATE:______________ MINOR___SINGLE___MARRIED___DIVORCED___SEX: MALE___FEMALE___

PATIENT____
LAST NAME FIRST INITIAL

******PERSON RESPONSIBLE FOR ACCOUNT******

LAST NAME ____________________ FIRST ____________________ INITIAL ________

ADDRESS ____

CITY ____________________ STATE ____________________ ZIP CODE ____________

TELEPHONE (HOME) ____________________ TELEPHONE (WORK) ____________________

EMPLOYER ____________________ POSITION ____________________ HOW LONG? ________

EMPLOYER ADDRESS ____

DENTAL INSURANCE CO. ____________________ SOC. SEC. NO. ____________________

******SPOUSE OF RESPONSIBLE PARTY******

LAST NAME ____________________ FIRST ____________________ INITIAL ________

EMPLOYER ____________________ POSITION ____________________ HOW LONG? ________

EMPLOYER ADDRESS ____________________ TELEPHONE (WORK) ____________________

DENTAL INSURANCE CO. ____________________ SOC. SEC. NO. ____________________

IN CASE OF AN EMERGENCY, WHO SHOULD BE NOTIFIED?

NAME ______________ RELATIONSHIP ______________ PHONE NO. ______________

HAS ANY MEMBER OF YOUR FAMILY BEEN TREATED IN OUR OFFICE? ______________

IF YES, NAME: ____

WHOM MAY WE THANK FOR REFERRING YOU? ________________________________

METHOD OF PAYMENT-PLEASE CHECK ONE OF THE FOLLOWING:

☐ PAYMENT IN FULL AT EACH APPOINTMENT
☐ PAYMENT OF CHARGES NOT COVERED BY INSURANCE IN FULL AT EACH APPOINTMENT (IN WHICH CASE BENEFITS OF INSURANCE WILL BE ________ ASSIGNED TO THIS OFFICE)
☐ MONTHLY BUDGET PAYMENTS (PRIOR ARRANGEMENTS MUST BE MADE)

******PLEASE NOTE THAT THE PATIENT IS ULTIMATELY RESPONSIBLE FOR THE PAYMENT OF FEES FOR ANY SERVICE RENDERED.**

Patient name ______________________ Birth date ______ MONTH DAY YEAR

How should we address you? ______________________

MEDICAL HISTORY

Who is your medical doctor? ______________________ Address ______________________

______________________ M.D. Phone ______________________

Date of last health exam ______________________ Purpose ______________________

Have you ever been hospitalized? ______ If so, for what ______________________

Have you ever smoked? YES ☐ NO ☐ ______________________

Do you have any orthopedic implants or heart implants? ______________________

Please list all of the medications which you are presently taking and why? ______________________

______________________, ______________________ (including aspirin)

Are you allergic to any medications? YES ☐ NO ☐ If so, please name. ______________________

Do you consume more than 2 alcoholic drinks per day? YES ☐ NO ☐ ______________________

May we request your health records if necessary YES ☐ NO ☐

Are you pregnant? YES ☐ NO ☐ Expected due date ______________________

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO		YES	NO
						Liver Disease	☐	☐
High blood pressure	☐	☐	Hyperthyroid	☐	☐	Ulcers	☐	☐
Heart problems	☐	☐	Cold Sores	☐	☐	Diabetes	☐	☐
Rheumatic fever	☐	☐	Hepatitis	☐	☐	Jaundice	☐	☐
Heart Murmur	☐	☐	Venereal disease	☐	☐	HIV Infected	☐	☐
Difficulty breathing	☐	☐	Kidney disease	☐	☐	Unintentional Weight Gain	☐	☐
Mitral Valve Prolapse	☐	☐	Stroke	☐	☐	Unintentional Weight Loss	☐	☐
Circulatory problems	☐	☐	Arthritis	☐	☐	Anemia	☐	☐
Excessive bleeding	☐	☐	Malignancies	☐	☐	Asthma	☐	☐
Low blood pressure	☐	☐	Tuberculosis	☐	☐	Hearing impairment	☐	☐
Radiation treatment	☐	☐	Epilepsy	☐	☐	Other	☐	☐

COMMENT LINE ______________________

DENTAL HISTORY

Reason for todays visit? ______________________ Last dental visit ______________________

Purpose ______________________ Last complete exam ______________________

How would you describe your present oral condition? Good ☐ Fair ☐ Poor ☐

Homecare: Brush ____________ Floss ____________

Do your gums bleed? Yes ☐ No ☐

Do you have bad breath or taste? Yes ☐ No ☐

Is keeping your natural teeth important to you? ______________________

Have you had any unusual effect from previous dental treatment? Yes ☐ No ☐

Describe ______________________

Children and Adolescents: Does your child have a nick-name? ______________________

Has this child ever had an unfavorable experience in a dental office? Explain ______________________

______________________ Does your child have a finger sucking habit? ______________________

AUTHORIZATION

I hereby authorize Anthony J. Tabone, D.D.S. to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I attest the information on this form is correct to the best of my knowledge.

*Signature ______________________ Date ______________________

*If patient is under 18 years of age, parent must sign for patient.

I have read my medical history dated ____________ and confirm that it adequately states past and present conditions.

DATE	SIGNATURE	B.P.	REVIEWED BY
______	______	______	Dr. ______
______	______	______	Dr. ______
______	______	______	Dr. ______