Dental Registration and History Form

PATIENT INFORMATION:

NAME Last_____ First_____ Sex ☐F ☐M SS#_____-_____-_____

Date of Birth _____ Home Phone_____ Work_____ Cell_____

Address_____

Email Address _____

IN CASE OF EMERGENCY, CONTACT: NAME Last First

Home Phone_____ Work_____ Cell_____

DENTAL INSURANCE INFORMATION:

Insured person_____ Relationship to Patient _____

Birth Date_____ SS#_____-_____-_____ Employer_____

Insurance Company_____

Group #_____ Do you have additional Insurance?_____

MEDICAL HISTORY: HAVE YOU EVER HAD:

1.Heart Disease	☐YES	☐NO	8. High blood pressure	☐YES	☐NO
2.Rheumatic Fever	☐YES	☐NO	9. Diabetes	☐YES	☐NO
3.*Tuberculosis*	☐YES	☐NO	*10.Radiation therapy*	☐YES	☐NO
4. Hepatitis	☐YES	☐NO	11.Kidney disease	☐YES	☐NO
5. Stroke	☐YES	☐NO	12.Bleeding problems	☐YES	☐NO
6 Asthma	☐YES	☐NO	13.Cancer	☐YES	☐NO
7.AIDS	☐YES	☐NO	14.HIV Positive	☐YES	☐NO

ARE YOU ALLERGIC TO PENICILLIN? ☐YES ☐NO

ARE YOU ALLERGIC TO ANY OTHER MEDICINE? ☐YES ☐NO

If YES, please list_____

DENTAL HISTORY:

1. When was your last dental exam?_____
2. When was your last full mouth x-ray taken? _____
3. Do you have any injuries in or around your mouth? ☐YES ☐NO
4. Have you ever had prolonged bleeding following extraction in the past? ☐YES ☐NO
5. Have you ever had any reaction or allergic symptoms to anesthetics? ☐YES ☐NO
6. Is there any other problems that you would like us to know?_____

If you are referred by your dentist or any other person, please provide:

Name_____Phone#_____

If the above does not apply, how else did you hear about us?

_____

By signing below, I agree to receive dental care at Agape Dental. I also agree that the dental office may file my insurance on my behalf (only if applicable).

_____ _____

PATIENT SIGNATURE DATE