

## PATIENT REGISTRATION FORM

|   |                           |        |               |            |                        |
|---|---------------------------|--------|---------------|------------|------------------------|
| Patient's Name Last   | First                     | Middle | Date of Birth | Sex        | Social Security Number |
| Patient's Address Street  | Apt #                     | City   | State         | Zip Code   | Home Phone             |
| Is Patient a minor? Yes No  | Parent or Guardian's Name |        | Home Phone    | Work Phone |                        |
| Marital Status<br>M S D W   | Spouse's Name             |        | Home Phone    | Work Phone |                        |
| Emergency person we can contact (other than your family home)<br>Name |                           |        | Home Phone    | Work Phone |                        |

### DENTAL PATIENT MEDICAL HISTORY

The answers to the following questions will assist the dentist in evaluating your general health prior to providing your dental treatment.

**PLEASE READ CAREFULLY AND ANSWER EACH QUESTION AS ACCURATELY AS POSSIBLE.**

|  |                                |                                |                              |  |
|--|--------------------------------|--------------------------------|------------------------------|--|
| 1. What is your impression of your present health?   | 2. Year Last Medical Physical? |                                |                              |  |
| 3. Circle any of the following which you have had or have at present:                                  |                                |                                |                              |  |
| Heart Disease or Condition   | Rheumatic Fever                | Asthma                         | Hepatitis                    | Venereal Disease (syphilis, gonorrhea, etc)                              |
| Angina Pectoris  | Stroke                         | Hay Fever                      | Thyroid Disease              |  |
| Frequent Chest Pains   | Hemophilia                     | Emphysema                      | Glaucoma                     | Drug Addiction   |
| High Blood Pressure  | Bruise Easily                  | Tuberculosis (TB)              | Epilepsy or Seizures         | Psychiatric Treatment  |
| Shortness of Breath  | Prolonged or Unusual Bleeding  | Diabetes                       | Fainting or Dizzy Spells     | Cancer   |
| Swollen Ankles   | Anemia                         | Ulcers                         | AIDS or AIDS Related Complex | Radiation Therapy  |
| Artificial Heart Valve   | Blood Transfusion              | Kidney Trouble                 | HIV Positive                 | Chemotherapy   |
| Congenital Heart Disease   | Sickle Cell Anemia             | Liver Disease                  | Cold Sores                   | Implant Prosthesis   |
| Heart Murmur   | Arthritis                      | Jaundice (other than at birth) | Genital Herpes               | Unexplained Weight Loss  |
| 4. ARE YOU PRESENTLY, OR HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN IN THE LAST YEAR?<br>PLEASE LIST: |                                |                                |                              | YES <input type="checkbox"/> NO <input type="checkbox"/>                 |
| 5. ARE YOU PRESENTLY TAKING ANY MEDICINE OR DRUGS?<br>PLEASE LIST:                                     |                                |                                |                              | YES <input type="checkbox"/> NO <input type="checkbox"/>                 |
| 6. ARE YOU ALLERGIC TO ANY MEDICINE OR MATERIALS?<br>PLEASE LIST:                                      |                                |                                |                              | YES <input type="checkbox"/> NO <input type="checkbox"/>                 |
| 7. HAVE YOU EVER HAD A REACTION TO A LOCAL ANESTHETIC?   |                                |                                |                              | YES <input type="checkbox"/> NO <input type="checkbox"/>                 |
| 8. HAVE YOU EVER EXPERIENCED ANY COMPLICATIONS FOLLOWING DENTAL TREATMENT?                             |                                |                                |                              | YES <input type="checkbox"/> NO <input type="checkbox"/>                 |
| 9. DO YOU HAVE ANY ILLNESSES OR DISEASES NOT LISTED ABOVE?   |                                |                                |                              | YES <input type="checkbox"/> NO <input type="checkbox"/>                 |
| 10. HAVE YOU EVER BEEN TOLD YOU WERE NOT ABLE TO BE A BLOOD DONOR?                                     |                                |                                |                              | YES <input type="checkbox"/> NO <input type="checkbox"/>                 |
| 11. DO YOU USE TOBACCO?  |                                |                                |                              | YES <input type="checkbox"/> NO <input type="checkbox"/>                 |
| 12. ARE YOU PREGNANT?  |                                |                                |                              | YES <input type="checkbox"/> TRIMESTER 1 2 3 NO <input type="checkbox"/> |

DENTIST'S COMMENTS:

### PRIVATE PAY AGREEMENT & CONSENT

I understand Progressive Dental Center, P.C. is accepting me as a private pay patient for the period in which my Medicaid Coverage is pending. I will be responsible for paying for any services that I receive. The provider will not file a claim to Medicaid for services provided to me while Medicaid coverage is not in effect. I consent to the taking of photographs and x-rays before, during and after treatment and to the use of same by the doctor in scientific papers or demonstrations.

SIGNATURE

DATE