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Patient Registration

" please print "

Housh Family Dentistry
605 E. Hospital Rd., Suite 1
El Dorado Springs, MO 64744
Phone: (417) 876-3124

Date _____ Cell phone _____ Cell phone carrier _____

Patient _____
Last Name *First Name* *Initial* *Preferred Name*

Street address _____ City _____ State____ Zip _____

Email address _____ Home phone _____

How would you prefer to be contacted? ☐ *Email* ☐ *Cell phone* ☐ *Home phone*

Sex ☐ Male ☐ Female Age____ Birth date _____ ☐ *Single* ☐ *Married* ☐ *Widowed* ☐ *Divorced*

Social Security number _____

Employed by _____ Occupation _____

☐ *Spouse* or ☐ *Parent* Name _____
Last Name *First Name* *Initial*

Birth date _____ Social Security number _____

Employed by _____ Occupation _____

Who is responsible for the account? _____ Relationship to the patient _____

Dental Insurance Company _____ Subscriber _____

Last Dental visit date _____ Doctor's Name _____

Medical History - ***Have you ever had any of the following?*** Please check mark every medical issue.

☐ Allergies	☐ Hemophilia	☐ Nervous problems	☐ High blood pressure
☐ Fainting	☐ Hepatitis A B C *Circle one*	☐ Food allergies	☐ Tuberculosis
☐ Anemia	☐ Kidney disease	☐ Arthritis	☐ Epilepsy
☐ Back problems	☐ AIDS / HIV positive	☐ Shortness of breath	☐ Radiation treatment
☐ Cancer	☐ Mitral valve prolapse	☐ Chemotherapy	☐ Venereal disease
☐ Stroke	☐ Psychiatric care	☐ Cortisone treatments	☐ Skin rash
☐ Cough, persistent	☐ Respiratory disease	☐ Liver disease	☐ Surgical implants
☐ Ulcers / Colitis	☐ Shingles	☐ Blood disorders	☐ Thyroid problems
☐ Diabetes	☐ Circulation problems	☐ Glaucoma	☐ Seizure disorders
☐ Pacemaker	☐ Herpes	☐ Rheumatic Fever	☐ Heart problems
☐ Headaches	☐ Tobacco use	☐ Swelling, feet or ankles	☐ Alcoholism

If any of the above were checked yes, or if you have something that is not listed above, please list the date and explain why. _____

Medical History - *Continued*

Please list any surgeries you have had, type and what year. _____

_____

_____

_____

Known Allergies ☐ Local Anesthetic ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Latex

Any other allergies not listed above?_____

_____

List all medications you are currently taking._____

_____

_____

_____

Consulting Physician _____ Preferred Pharmacy_____

Has your physician told you that you need or in the past have needed premedicated with antibiotics before Dental treatment? If so, for what reason._____

_____

_____

How did you hear about us? Family / Friend _____

Authorization:

I have reviewed the information and answered all questions to the best of my knowledge. I understand this information will be used to determine the dental treatment I receive at this office and may be shared with other medical offices only as necessary. I will notify the office should any information change in the future.

Signature of patient, or parent if a minor: _____ Date _____

Reviewed by:_____ Date _____