



TYSON'S CORNER DENTAL ARTS CENTER
PATIENT REGISTRATION AND MEDICAL HISTORY

Date \_\_\_\_\_ Email Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Patient \_\_\_\_\_
Last Name First Name Initial Preferred Name

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex: [ ] M [ ] F Age \_\_\_\_\_ Birthday \_\_\_\_\_ [ ] Single [ ] Married [ ] Widowed [ ] Separated [ ] Divorced

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Spouse/Parent Name \_\_\_\_\_ Spouse Birth date \_\_\_\_\_

Spouse/Parent Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Social Security # \_\_\_\_\_ Spouses Social Security # \_\_\_\_\_

Primary Insurance Company Name \_\_\_\_\_ Group Number \_\_\_\_\_

Second Insurance Company Name (If Applicable) \_\_\_\_\_ Group Number \_\_\_\_\_

In case of emergency, who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of Last Physical \_\_\_\_\_

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

- Yes No Yes No Yes No
[ ] [ ] Heart Problems [ ] [ ] Epilepsy [ ] [ ] Special Diet
[ ] [ ] Heart Murmur [ ] [ ] Headaches [ ] [ ] Swollen Neck Glands
[ ] [ ] High/Low Blood Pressure [ ] [ ] Hepatitis, Jaundice or Liver Disease [ ] [ ] Rheumatic Fever
[ ] [ ] Artificial Heart Valves or Joints [ ] [ ] Cancer [ ] [ ] Sinus Problems
[ ] [ ] Circulatory Problems [ ] [ ] Psychiatric Care [ ] [ ] "A.I.D.S." or Other
[ ] [ ] Nervous Problems [ ] [ ] Chronic Diarrhea [ ] [ ] Immunosuppressive Disorders
[ ] [ ] Radiation Treatment [ ] [ ] Allergies to Anesthetics [ ] [ ] Stroke
[ ] [ ] Recent Weight Loss [ ] [ ] Allergies to Medicine or Drugs [ ] [ ] Ulcer
[ ] [ ] Back Problems [ ] [ ] General Allergies [ ] [ ] Venereal Disease
[ ] [ ] Diabetes [ ] [ ] Blood Disease [ ] [ ] Chemical Dependency
[ ] [ ] Respiratory Disease [ ] [ ] Arthritis [ ] [ ] Hemophilia

Date of last dental check-up \_\_\_\_\_ Dentist's Name \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

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

PLEASE READ AND SIGN:

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. There will be a \$60.00 per 1/2 hour charge for appointments cancelled or broken without 48 hours advance notice (No exceptions). It is agreed that all expenses incurred by our office in enforcing its rights to payment for services rendered, including attorney's fees in the amount of \$35% and all other court costs so incurred shall be recoverable from the client (patient).

Signature X \_\_\_\_\_ Date \_\_\_\_\_