Patient Registration

First Name: _____ Last Name: _____

Address: _____

Date of Birth: _____ Cell Phone: _____ Home Phone: _____

Email: _____ Referred By: _____

Primary Dental Insurance Information

Name of Insured: _____ Insurance Company: _____

Insured Social Security: _____ Insured Date of Birth: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child Employer: _____

Medical History

List of Medications: _____

List of Allergies: _____

Do you have any of the following, please circle

AIDS/HIV	Excessive Bleeding
Artificial Heart Valve or Joint	Heart Disease
Asthma	Hepatitis
Chemotherapy	High Blood Pressure
Chest Pains	Osteoporosis
Diabetes	Pregnant or Trying
Drug Addiction	Psychiatric Care or Seizures

Are you taking or have you taken bisphosphonates? YES NO

Are you taking any blood thinners? YES NO

Are you being treated for any medical conditions? _____

_____

Signature X_____ Date: _____