# FAMILY DENTAL ASSOCIATES
## PATIENT REGISTRATION & HEALTH HISTORY

DATE: _____

**PATIENT INFORMATION:**

LAST NAME _____ FIRST NAME _____ MIDDLE _____ TITLE _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

HOME TELEPHONE _____ BUSINESS _____ CELL _____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____ E-MAIL _____

**DENTAL INSURANCE INFORMATION:**

Are you covered by Dental Insurance? ❑ Yes ❑ No Subscriber's SS/ID # _____

Subscriber's Name _____

Subscriber's Employer _____ Dental Insurance _____

Insurance Mailing Address _____

Telephone # _____ Group # _____ Subscriber's DOB _____

**Secondary Insurance** (if applicable) _____

Subscriber's Name: _____ Subscriber's SS/ID # _____

Subscriber's Employer _____ Dental Insurance _____

Insurance Mailing Address _____

Telephone# _____ Group # _____ Subscriber's DOB _____

**HAVE YOU HAD THE FOLLOWING:** ❑ Yes ❑ No

- ❑ Heart Problems
- ❑ Heart Murmur
- ❑ Angina
- ❑ Diabetes
- ❑ Cancer
- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ HIV / AIDS
- ❑ Kidney Disease
- ❑ Epilepsy
- ❑ Nervous Disorders
- ❑ Stomach Disorders
- ❑ Rheumatic Fever
- ❑ Thyroid Disease
- ❑ Hepatitis
- ❑ Liver Disease
- ❑ Mitrovalve Prolapse
- ❑ Sexually Transmitted Disease
- ❑ Irregular Heart Beat
- ❑ High Blood Pressure
- ❑ Scarlet Fever
- ❑ Lung Disease
- ❑ Tuberculosis
- ❑ Joint Replacement

**WOMEN ONLY:**

Are you pregnant? ❑ Yes ❑ No

How long? _____

Do you take birth control pills or hormone supplements? _____

**MEDICAL HISTORY**

Physician's Name: _____ Phone #: _____

Have you ever been treated with radiation? ❑ Yes ❑ No Are you being treated with anything now? _____

Are you allergic to? ❑ Penicillin ❑ Codeine ❑ Novocaine Other? _____

Do you take any prescription or over the counter drugs (including aspirin) on a regular basis? ❑ Yes ❑ No

If yes, Please list: _____

**DENTAL HISTORY**

How long since last dental exam? _____

Dental concerns: _____

**EMERGENCY CONTACT:** _____ **TELEPHONE #:** _____

**REFERRED BY:** _____ **SIGNATURE:** _____