PATIENT REGISTRATION FORM

*Date: _____
m/d/yy

*Patient Name: _____ *M ◯ F ◯

I prefer to be called: _____ *(First, Last, Middle Initial) _____

*Address:

_____

*Birth Date: _____ *SSN: _____
m/d/yy

*Home Phone: _____ *Email Address: _____

*Work Phone: _____ *What is the best way to reach you? _____

*Cell Phone: _____

*Appointment reminders are sent through e-mail or text messages. Please provide one or the other if you would like to receive appointment reminders

Person Responsible for Account: _____

*Name: _____ *Home Phone: _____

*Address:

_____

*Work Phone: _____ *SSN: _____

*Who should we contact in case of an emergency: _____

*Name: *Phone:

*Who can we thank for referring you to our office?

MEDICAL HISTORY:

*Physician's name:

City: Phone:

*Have you taken cortico steroids and/or blood thinners including aspirin recently and for how long?

* Yes No

If yes, please explain:

*Are you taking any medication, herbal supplements, or drugs now? Yes No

If so, please list:

*Are you sensitive (allergic) to any drugs or anesthetics?

Penicillin Aspirin Codeine Sulfa Novocaine Other

*Please indicate which of the following you have had or presently have (check all that apply)

Heart Surgery/Disease/ Attack
Diabetes
Congenital Heart Disease
Blood Transfusion
Heart Murmur
Asthma
Sinus Trouble
Fainting or Dizzy Spells
Drug or alcohol Abuse
Nervousness/Anxiety
Ulcers
Immunocompromised Disease
Venereal Disease
Thyroid Problems
Mitral Valve Prolapse
Arificial Heart Valve
Tuberculosis

- [ ] Hay Fever
- [ ] Epilepsy or Seizures
- [ ] Artificial Joint
- [ ] Tumors
- [ ] Low Blood Pressure
- [ ] Hepatitis A (infectious) B (serum)
- [ ] High Blood Pressure
- [ ] Emphysema
- [ ] Hemophilia
- [ ] Rheumatic Fever
- [ ] Latex Sensitivity
- [ ] Radiation Therapy
- [ ] Other
- [ ] Chemotherapy
- [ ] Psychiatric Care
- [ ] High Cholesterol
- [ ] Persistant Cough for 3 weeks or longer
- [ ] Weight Loss
- [ ] Fever/Night Sweats
- [ ] Coughing up Blood
- [ ] Chest Pain
- [ ] Hoarseness
- [ ] Swollen lymph nodes
- [ ] Cold Sores/Fever Blisters
- [ ] None of the above

**Women: Are you: Pregnant:* ◯ *Yes* ◯ *No* ◯ *N/A*

**Nursing?* ◯ *Yes* ◯ *No* ◯ *N/A*

** Taking Birth Control Pills* ◯ *Yes* ◯ *No* ◯ *N/A*

I understand the above information is necessary to provide me with dental care in a safe and effective manner. I have answered the questions to the best of my knowledge. I understand I am responsible for all cost of dental treatment. I hereby authorize this office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

- Pursuant to Virginia Law 32.1-45.1 – Any patient who exposes a health care provider or his employee/agent to body fluid in a manner which may transmit the human immunodeficiency virus (HIV), Hepatitis B or C virus is deemed to have consented to HIV, Hepatitis B and C testing and disclosure of the results to the person exposed. This deemed consent also applies to a health care provider who exposes a patient to body fluid in the above stated manner.

Signature: _____ *Date: _____

Patient, Parent or Guardian

m/d/yy

Once you get to our practice to your appointment, we'll ask you to sign the form.