PATIENT REGISTRATION

Please Print

Cell Phone ( ) _____

Date _____ Date of Birth _____ Age _____ Home Phone ( ) _____

Patient Name _____ Sex _____ Marital Status S M W D
Last First M.I.

Address _____ Apt. # _____

City _____ State _____ Zip Code _____ SS# _____

Your Employer _____ Work Phone _____

Occupation or previous occupation _____

Responsible Party _____ Work Phone ( ) _____

Responsible Party Employer _____

In case of emergency, please contact _____ Phone _____

Name of Person filling out this form _____ Relationship to Patient _____

Your best contact Phone Number _____

If patient is a minor, please complete the following:

Father Name _____ SS# _____ Phone _____

Mother Name _____ SS# _____ Phone _____

If you have medical coverage, please complete below:

Name of Primary Insurance _____ ID# _____

Group/Plan _____ SS# of Policy Holder _____

Name of Policy Holder _____ Phone # _____

Name of Secondary Insurance (if applicable) _____ ID# _____

Group/Plan _____ Name of Policy Holder _____

SS# of Policy Holder _____ Birthdate _____

Check any below that apply to you:

☐ Asthma	☐ Diabetes	☐ Hypertension	☐ Psychiatric Disorder	☐ Snoring/Sleep Problems
☐ Bleeding Tendencies	☐ Glaucoma	☐ Jaundice	☐ Trouble Hearing	☐ Arthritis
☐ Cancer	☐ Heart Trouble	☐ Kidney Disease	☐ Lung Disorder	☐ Stroke

Were you ever hospitalized for an illness not requiring surgery? _____ Explain: _____

_____

Were you ever hospitalized for an operation? _____ Give name of operation, date, surgeon, hospital _____

_____

Are you allergic or sensitive to medicines or other substances? _____ List _____

Do you use alcoholic beverages? _____ Type _____ How Long? _____ Amount _____

Do you currently use tobacco? _____ Quantity? _____ How Many Years? _____

Any previous use of tobacco? _____ Quantity? _____ How Many Years? _____

Do you have any dental problems now? _____ Explain _____

Are you currently taking any medicines? _____ Names _____

_____

Who referred you to our office? _____

PLEASE READ AND SIGN OTHER SIDE