PATIENT REGISTRATION FORM **DATE** _____

Patient's Name _____ Address _____
Last First M.I. Number & Street

_____ Birthdate _____ Weight _____
City State Zip Code

Home Phone _____ Bus. Phone _____ Ext. or Dept. _____

Employed by _____ Address _____

Occupation _____ Closest Relative _____ Phone _____

Married ☐ Single ☐ Widowed ☐ Divorced ☐ Spouse's Name _____

Spouse Employed by _____ Bus. Phone _____ Ext. or Dept. _____

Person responsible for account: _____

Mailing address (If different than above) _____

Home Phone _____ Employed by _____ Bus. phone _____

Soc. Sec. No. _____

If you have dental insurance, please complete:

Insurance Company _____ Group or employer name _____

Subscriber's name _____ Subscriber's soc. sec. no. _____

Subscriber's date of birth _____

PLEASE ANSWER EACH QUESTION **CIRCLE**

1. Have you been a patient in a hospital in the past 2 years? YES NO
2. Have you been under the care of a physician during the past 2 years? YES NO
3. Have you taken any kind of medicine or drugs recently? YES NO

   If yes, what? _____
4. Are you allergic to penicillin, codeine, or any other drugs? YES NO

   If yes, what? _____
5. <u>Please write yes or no after each of the following. Have you had or been told you have:</u>

Heart Trouble _____	Jaundice _____	Arthritis _____
Congenital Heart Lesions _____	Asthma/Allergies _____	Stroke _____
Heart Murmur/Mitral Valve Prolapse _____	Diabetes/High Sugar _____	Epilepsy/Seizures _____
High Blood Pressure _____	Tuberculosis _____	Psychiatric Treatment _____
Anemia _____	Hepatitis _____	Sinus Trouble _____
Rheumatic Fever _____	AIDS (HIV Positive) _____	Venereal Disease _____
Alcoholism _____	Joint Replacement _____	I.V./Drug User _____

6. Have you ever had any other serious illness/surgery? YES NO

   If yes, what? _____
7. Have you ever had any excessive bleeding requiring special treatment? YES NO
8. (Women) Are you pregnant? YES NO

_____
Signature (patient or responsible party)

_____
Reviewed by