

**Gainesville Family Dental Center
Patient Registration and Medical History**

Date: _____ Home Phone: _____ Cell Phone: _____

***Primary language: _____ English _____ Spanish _____ Work Phone: _____

Who may we thank for referring you? _____

Patient: _____
LAST NAME FIRST MIDDLE INITIAL (PREFERRED NAME)

Street Address: _____ City: _____ ST: _____ Zip: _____

Sex: _____ M _____ F Age: _____ Birth date: _____ Single: _____ Married: _____ Separated: _____

SSN: _____ Employed by: _____

Spouse/Parent Name: _____ Birth date: _____

Spouse/Parent SSN: _____ Name of Insured: _____ Relation to Patient: _____

Who is responsible for this account? _____ Relation to Patient: _____

Birth Date: _____ SSN: _____

When was your last dental visit? What treatment did you receive? _____

Who should we call in case of an emergency? _____ Phone #: _____

Physician's Name: _____ Last Physical: _____

Do you need Pre-medication? _____ Are you taking medication at this time? _____

Are you under the care of a physician? Why? _____

Do you suspect that you may be pregnant? _____ Due Date: _____

Are you taking birth control? _____ (Certain medications may interfere with contraceptives)

Have you ever had any of the following? (CHECK ALL EITHER YES OR NO)

N	Y		N	Y		N	Y		LIST OF MEDS	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valves	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS/Arc	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Neck Glands	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Blood Thinners	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Mental Disorders	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to Anesthetic	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to Medicine	<input type="checkbox"/>	<input type="checkbox"/>	Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to Tetracycline	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to Latex	<input type="checkbox"/>	<input type="checkbox"/>	Hx of Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	General Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Hx of Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>

The above information is accurate and complete to the best of my knowledge. Since a change in medical condition or medication can affect dental treatment, I will inform the office of any changes at any subsequent appointment. I will not hold the dentist or any member of his/her staff responsible for any errors of omissions that I might have in completing this form.

Signature of Patient/Parent/Guardian _____ Date _____ Doctors Signature _____ Date _____