Brad Bath D.D.S. P.C.

PATIENT REGISTRATION & MEDICAL HISTORY

(PLEASE PRINT)

Date_____

Home Phone_____

Patient_____
Last Name First Name Initial Preferred Name

Street Address_____City_____State_____Zip_____

Sex: ☐ M ☐ F Age_____Birthdate_____ ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorce

If Student, Name of School/College_____City_____State_____ ☐ Full-Time ☐ Part-Time

Responsible Party_____Relationship to patient_____

Billing Address_____

Home Phone_____Cell Phone_____Social Security #_____Birthdate_____

Employed by_____Occupation_____

Business Address_____Business Phone_____

Spouse Name_____Spouse Birthdate_____

Spouse Employed by_____Occupation_____

Business Address_____ Business Phone_____

In case of emergency, who should be notified?_____Phone_____

Method of Payment: ☐ Visa/MC ☐ Cash ☐ Discover Card ☐ Insurance

DENTAL SERVICES ARE RENDERED ON A CASH BASIS ONLY UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE.

INSURANCE INFORMATION

Name of Insured_____Relationship to patient_____

Birthdate_____ SS#/SIN_____Date Employed_____

Name of Employer_____Work Phone_____

Employer Address_____City_____ State_____ Zip_____

Dental Insurance Co. Name_____Group Number_____Policy/ID#_____

Ins. Co. Address_____City_____State_____Zip_____

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following

Name of Insured_____Relationship to patient_____

Birthdate_____ SS#/SIN_____Date Employed_____

Name of Employer_____Work Phone_____

Employer Address_____City_____ State_____ Zip_____

Dental Insurance Co. Name_____Group Number_____Policy/ID#_____

Ins. Co. Address_____City_____State_____Zip_____

- Turn over please -

PATIENT MEDICAL HISTORY

Family Physician_____Address_____

Phone_____Date of Last Exam_____

Former Dentist_____Address_____

Date of Last Exam_____Do you have recent x-rays?_____

Have you ever had any of the following? (check boxes that apply):

- ☐ Heart Problems
- ☐ Pacemaker
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Hemophillia/Bleeding Disorder
- ☐ Blood Disease
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Artificial Heart Valves or Joints
- ☐ Any Artificial Joints
- ☐ Arthritis
- ☐ Recent Weight Loss
- ☐ Special Diet
- ☐ Back Problems
- ☐ Diabetes
- ☐ Sinus Problems
- ☐ Respiratory Disease
- ☐ COPD
- ☐ Emphysema
- ☐ Asthma
- ☐ Epilepsy/Seizure Disorder
- ☐ Headaches
- ☐ Cancer
- ☐ Chronic Diarrhea
- ☐ Swollen Neck Glands
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Disease
- ☐ HIV/AIDS
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Jaundice/Liver Disease
- ☐ Stroke
- ☐ Ulcer
- ☐ Latex Allergy
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ General Allergies
- ☐ Psychiatric Care
- ☐ Chemical Dependency

Do you have any drug allergies or have you ever had an adverse reaction to any medication?_____ If so, what?_____

_____

Have you ever responded adversely to medical or dental treatment?_____

Please list medications you are currently taking:

1._____for_____

2._____for_____

3._____for_____

Are you under the care of a physician? ☐ Yes ☐ No

For what conditions?_____

If patient is a child, what is his/her weight?_____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Are you taking an oral contraceptive? ☐ Yes ☐ No

Is there anything else we should know about your medical history?_____

_____

Do you have an allergy to latex? ☐ Yes ☐ No

Do you need antibiotic pre-medication for dental treatment? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No If yes, Type_____How Much?_____

DENTAL HISTORY

Are you having discomfort at this time?_____describe_____

Are your teeth sensitive to: heat_____cold_____sweets_____other_____

Have you had periodontal gum surgery or treatment?_____

How often do you brush your teeth?_____do your gums bleed?_____

Do you grind your teeth?_____do you have pain or clicking in the jaw?_____

Do you have any type of removable appliance? (dentures/partials)_____

If so, how old?_____

Is there anything that you would like to change about your smile?_____

Whom may we thank for referring you?_____

Date_____Signature_____