

# Dental Care Center- Free Dental Day

## Harrold, Higgins, Mani, Watson

### Patient Registration

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last, First MI ( Preferred Name)

Gender \_\_\_\_\_ Marital Status: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Cell): \_\_\_\_\_ email: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #

\_\_\_\_\_ City State Zip Code

### Health Information

**Have you ever had any of the following? Please check those that apply:**

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> AIDS                | <input type="checkbox"/> Excessive Bleeding   | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Allergies _____     | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Mental Disorders     | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> Tumors             |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Growths              | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Artificial Joints   | <input type="checkbox"/> Hay Fever            | <input type="checkbox"/> Pregnancy            | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Head Injuries        | <input type="checkbox"/> Due date: _____      | <input type="checkbox"/> Codeine Allergy    |
| <input type="checkbox"/> Blood Disease       | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Radiation Treatment  | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Respiratory Problems | OTHER:                                      |
| <input type="checkbox"/> Diabetes Type _____ | <input type="checkbox"/> Hepatitis Type _____ | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Latex allergy      |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Rheumatism           | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Jaundice             | <input type="checkbox"/> Sinus Problems       |   |
|  | <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Stomach Problems     |   |

• Have you been advised by your physician to pre-medicate prior to dental treatments?  Yes  No

Have you ever had any complications following dental treatment?  Yes  No

If yes, please explain: \_\_\_\_\_

• Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No

If yes, please explain: \_\_\_\_\_

• Are you now under the care of a physician?  Yes  No

If yes, please explain: \_\_\_\_\_

• Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

• Do you have any health problems that need further clarification?  Yes  No

If yes, please explain: \_\_\_\_\_

• Please list any medications, including non-prescription drugs, taken on a regular basis \_\_\_\_\_

**Are you Currently Employed?**  Yes  No **Occupation:** \_\_\_\_\_

**Do you currently have Dental Insurance?**  Yes  No

To the best of my knowledge, all of the preceding answers and information provided are true and correct.

\_\_\_\_\_  
 Signature of patient, parent or guardian Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

**Regarding HIPPA...** We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to make you aware of our privacy practices. By signing below you acknowledge that you have received a copy of our HIPAA guidelines. Thank you.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Doctor** \_\_\_\_\_  **RDH** \_\_\_\_\_