'IME 11:07 AM

DATE 10/28/2016

PATIENT REGISTRATION

ID: ______ Chart ID: ______

First Name: ______ Last Name: ______ Middle Initial: ______

Patient Is: ☐ Policy Holder ☐ Responsible Party

Preferred Name: ______

Responsible Party (if someone other than the patient)

First Name: ______ Last Name: ______ Middle Initial: ______

Address: ______ Address 2: ______

City, State, Zip: ______ Pager: ______

Home Phone: ______ Work Phone: ______ Ext: ______ Cellular: ______

Birth Date: ______ Soc Sec: ______ Drivers Lic: ______

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: ______ Address 2: ______

City: ______ State / Zip: ______ ______ Pager: ______

Home Phone: ______ Work Phone: ______ Ext: ______ Cellular: ______

Sex: ○ Male ○ Female

Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: ______ Age: ______ Soc. Sec: ______ Drivers Lic: ______

E-mail: ______ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: ______ Pref. Dentist: ______

Employer ID: ______ Pref. Pharmacy: ______

Carrier ID: ______ Pref. Hyg.: ______

Section 3

Emergency Contact: ______

Relationship: ______

Phone Number: ______

Primary Insurance Information

Name of Insured: ______ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ______ Insured Birth Date: ______

Employer: ______

Address: ______

Address 2: ______

City,State,Zip: ______

Ins. Company: ______

Address: ______

Address 2: ______

City,State,Zip: ______

Rem. Benefits: ______.00 Rem. Deduct: ______.00

Secondary Insurance Information

Name of Insured: ______ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: ______ Insured Birth Date: ______

Employer: ______

Address: ______

Address 2: ______

City,State,Zip: ______

Ins. Company: ______

Address: ______

Address 2: ______

City,State,Zip: ______

Rem. Benefits: ______.00 Rem. Deduct: ______.00

Time 11:15 AM

Barrett G.Moore D.D.S., PA _Assoc.

Medical History Updated

Date 10/28/2016

Patient Name: Birth Date: Date Created:

Contact Information

Please update your contact information by writing each number/email beside the corresponding box. Check your preferred way for us to reach you.

- ☐ Email
- ☐ Cell Phone
- ☐ Home Phone
- ☐ Work Phone

Do you have any new insurance information? ◯ Yes ◯ No

Please List your Emergency Contact: ______________________
Relationship to you: ______________________
Phone Number: ______________________

If yes to any of the following questions please explain.

Question	Answer	If yes
Are you currently under the care of a physician?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had surgery?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, drugs, or over the counter supplements?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	If yes
Have you ever been told you need to take an antibiotic prior to your dental appointments?	◯ Yes ◯ No	If yes
Do you use or have you ever used tobacco?	◯ Yes ◯ No	If yes

Women Only: Are you...

- ☐ Pregnant/Trying to get pregnant?
- ☐ Nursing?
- ☐ Taking oral contraceptives?

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Acrylic
- ☐ Metal
- ☐ Latex
- ☐ Sulfa Drugs
- ☐ Local Anesthetics

Do you have any other allergies not listed above: ◯ Yes ◯ No If yes

Do you have, or have you had, any of the following?

Condition	Answer	Condition	Answer	Condition	Answer	Condition	Answer
AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Acid Reflux	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Herpes (Oral or Genital)	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No
Scarlet Fever	◯ Yes ◯ No	Arthritis/Gout	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No
Epilepsy or Siezures	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No
Shingles	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No
Fainting Spells/Dizziness	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No
Sinus Trouble	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No	Blood Disease	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No	Bruise Easily	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No
Leukemia	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Glacuoma	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No
Heart Murmur	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No
Stroke	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No	Tonsilitis	◯ Yes ◯ No
Tuberculosis	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No	Cold Sores/Fever Blisters	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Convulsions	◯ Yes ◯ No	Heart Pace Maker	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No
Pain in Jaw Joints	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Yellow Jaundice	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No

Question	Answer	If yes
If you answered yes for any of the above please explain...	◯ Yes ◯ No	If yes
Have you ever had any serious illness, hospitalized, or diagnosis of a conditon not listed above?	◯ Yes ◯ No	If yes

Additional Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:__________