PLEASE PRINT
PATIENT REGISTRATION

OFFICE USE ONLY
Date Completed _____
Date Updated _____

REFERRED BY _____

MR
MRS
MISS
PATIENT LAST NAME FIRST NAME MIDDLE

SOCIAL SECURITY NUMBER DATE OF BIRTH AGE

ADDRESS STREET Apt. # CITY STATE ZIP

HOME PHONE SEX MARITAL STATUS EMAIL ADDRESS

EMPLOYED BY OCCUPATION BUSINESS PHONE CELL PHONE

SPOUSE'S NAME OCCUPATION BUSINESS PHONE CELL PHONE

☐ HOME ☐ BUSINESS ☐ CELL

SPOUSE'S EMPLOYER BEST NUMBER TO REACH YOU

NEAREST FRIEND OR RELATIVE (Not living with patient) RELATIONSHIP TO PATIENT PHONE

RESPONSIBLE PARTY
IF PATIENT NOT RESPONSIBLE FOR THE BILL. PLEASE INDICATE WHO IS RESPONSIBLE FOR THE BILL:

NAME ADDRESS CITY STATE ZIP CODE

HOME PHONE RELATIONSHIP TO PATIENT OCCUPATION

EMPLOYER EMPLOYER'S ADDRESS CITY STATE ZIP BUS PHONE

METHOD OF PAYMENT: ☐ CASH ☐ CHECK ☐ CREDIT CARD (MC DSC VISA AMEX) ☐ CARE CREDIT

INSURANCE INFORMATION

COMPANY SUBSCRIBER NO POLICY NO COMPANY SUBSCRIBER NO POLICY NO

MEDICAID NO MEDICARE NO

WORKER'S COMPENSATION NAME OF COMPANY

ADDRESS OF COMPANY COMPANY PHONE TREATMENT AUTHORIZED BY

MEDICAL HISTORY (LONG FORM)

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health? YES NO
2. Has there been any change in your general health within the past year? YES NO
3. My last physical examination was on. _____
4. Are you now under the care of a physician? YES NO
   a. If so, what is the condition being treated? _____
5. The name and address of my physician is _____
6. Have you had any serious illness or operation? YES NO
   a. If so, what was the illness or operation? _____
7. Have you been hospitalized or had a serious illness within the past five (5) years? YES NO
   a. If so, what was the problem? _____
8. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves or artificial heart valves YES NO
   b. Congential heart lesions YES NO
   c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) YES NO
      1) Do you have pain in chest upon exertion? YES NO
      2) Are you ever short of breath after mild exercise? YES NO
      3) Do your ankles swell? YES NO
      4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep? YES NO
      5) Do you have a cardiac pacemaker? YES NO
   d. Allergy YES NO
   e. Sinus trouble YES NO
   f. Asthma or hay fever YES NO
   g. Hives or a skin rash YES NO
   h. Fainting spells or seizures YES NO
   i. Diabetes YES NO
      1) Do you have to urinate (pass water) more than six times a day? YES NO
      2) Are you thirsty much of the time? YES NO
      3) Does your mouth frequently become dry? YES NO
   j. Hepatitis, jaundice or liver disease YES NO
   k. Arthritis YES NO
   l. Inflammatory rheumatism (painful swollen joints) YES NO
   m. Stomach ulcers YES NO
   n. Kidney trouble YES NO
   o. Tuberculosis YES NO
   p. Do you have a persistent cough or cough up blood? YES NO
   q. Low blood pressure YES NO
   r. Venereal disease YES NO
   s. AIDS YES NO
   t. Sjogren's syndrome or any other autoimmune disease. YES NO
   u. Other _____
9. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? YES NO
   a. Do you bruise easily YES NO
   b. Have you ever required a blood transfusion? YES NO
      If so, explain the circumstances _____
10. Do you have any blood disorder such as anemia? YES NO
11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your head or neck? YES NO
12. Are you taking any drug or medicine? YES NO
    If so, what? _____