



CHANTILLY DENTAL ARTS CENTER
PATIENT REGISTRATION AND MEDICAL HISTORY

Date Email address Home Phone

Patient Last Name First Name Initial Preferred Name

Street Address City State Zip

Sex: M F Age Birthday Single Married Widowed Separated Divorced

Employed by Occupation

Business Address Business Phone

Spouse/Parent Name Spouse Birth date

Spouse/Parent Employed by Occupation

Business Address Business Phone

Who is responsible for this account? Relationship to Patient

Social Security # Spouses Social Security #

Primary Insurance Company Name Group Number

Second Insurance Company Name (If Applicable) Group Number

In case of emergency, who should be notified? Phone

Whom may we thank for referring you?

MEDICAL HISTORY

Physician's Name Date of Last Physical

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

- Yes No Heart Problems, Heart Murmur, High/Low Blood Pressure, Artificial Heart Valves or Joints, Circulatory Problems, Nervous Problems, Radiation Treatment, Recent Weight Loss, Back Problems, Diabetes, Respiratory Disease, Epilepsy, Headaches, Hepatitis, Jaundice or Liver Disease, Cancer, Psychiatric Care, Chronic Diarrhea, Allergies to Anesthetics, Allergies to Medicine or Drugs, General Allergies, Blood Disease, Arthritis, Special Diet, Swollen Neck Glands, Rheumatic Fever, Sinus Problems, A.I.D.S. or Other, Immunosuppressive Disorders, Stroke, Ulcer, Venereal Disease, Chemical Dependency, Hemophilia

Date of last dental check-up Dentist's Name

Reason for today's visit:

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?

Are you taking any medication at this time? If so, what

Are you under the care of a physician? Yes No For what conditions?

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

PLEASE READ AND SIGN:

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

There will be a \$60.00 per 1/2 hour charge for appointments cancelled or broken without 48 hours advance notice (No exceptions). It is agreed that all expenses incurred by our office in enforcing its rights to payment for services rendered, including attorney's fees in the amount of 25% and all other court costs so incurred shall be recoverable from the client (patient).

Signature X Date

## MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment?  Yes  No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what \_\_\_\_\_

Date

Signature

## MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment?  Yes  No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what \_\_\_\_\_

Date

Signature

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