



ROSSLYN 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

- Yes No
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

- Yes No
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.

There will be a \$60.00 per 1/2 hour charge for appointments cancelled or broken without 24 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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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

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Signature