Roslyn
FAMILY DENTAL

PATIENT REGISTRATION

First Name: ______________________________ Last Name: __________________________ Middle Initial: __

Patient is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _______________________

Patient Information

Address: ________________________________ Address 2: ____

City: ____________________________________ State/Zip: _____________________

Cellular: ______________ Home Phone: ____________________ Work Phone ________________ Ext.: _____

Sex: ☐ Male ☐ Female

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

Birth Date: _________________________ Age: _________ Soc Sec: _________________________________

Email: _______________________________________ Referred by:__________________________________

Section 2

Employment Status:

☐ Full Time ☐ Part Time ☐ Retired

Student Status:

☐ Full Time ☐ Part Time

Previous dentist: ______________________________

Section 3

Emergency Contact: ___________________________

Emergency Contact #: _________________________

Pharmacy Name: ______________________________

Pharmacy Phone # : ___________________________

Insurance Information

Primary: _______________________________________ Relationship to Insured: Self / Spouse / Child / Other

Name of Insured: ____________________________ Insurance ID#: ___________________________________

Insured Soc. Sec: ____________________________ Insurance Company: ____________________________

Employer: ___________________________________ Responsible Party: _____________________________

Relationship to Patient: ____________________________

Insurance Information

Secondary: _____________________________________ Relationship to Insured: Self / Spouse / Child / Other

Name of Insured: ____________________________ Insurance ID#: ___________________________________

Insured Soc. Sec: ____________________________ Insurance Company: ____________________________

Employer: ___________________________________ Responsible Party: _____________________________

Relationship to Patient: ____________________________

Are you currently under a physician's care? Yes / No Physician's Name: ____________________

Have you ever been hospitalized or had a major operation Yes / No

If Yes, Describe: ____________________

Women: Are you Pregnant / Trying to get pregnant / Nursing / Using an oral contraceptive

Are you taking any medications: ☐ Yes / ☐ No

If Yes: ____________________

Do you or have you taken hen-Fen or Redux? ☐ Yes / ☐ No

Do you use controlled substances? ☐ Yes / ☐ No

If Yes: ____________________

Have you ever taken Fosamax, Boniva or Actonel? ☐ Yes / ☐ No

If Yes, have you taken medications containing bisphosphonate? ☐ Yes / ☐ No

Are you on a special diet? ☐ Yes / ☐ No

Do you use tobacco? ☐ Yes / ☐ No

Are you allergic to any of the following:

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

Do you have or have you had any of the following:

AIDS/HIV Positive	☐ Yes / ☐ No	Cold Sores	☐ Yes / ☐ No	Hay Fever	☐ Yes / ☐ No
Alzheimer's Disease	☐ Yes / ☐ No	Convulsions	☐ Yes / ☐ No	Heart Attack/Failure	☐ Yes / ☐ No
Anaphylaxis	☐ Yes / ☐ No	Cortisone Medicine	☐ Yes / ☐ No	Heart Disease	☐ Yes / ☐ No
Anemia	☐ Yes / ☐ No	Drug Addition	☐ Yes / ☐ No	Heart Disorder	☐ Yes / ☐ No
Angina	☐ Yes / ☐ No	Easily Winded	☐ Yes / ☐ No	Heart Murmur	☐ Yes / ☐ No
Arthritis/Gout	☐ Yes / ☐ No	Emphysema	☐ Yes / ☐ No	Heart Pacemaker	☐ Yes / ☐ No
Artificial Heart Valve	☐ Yes / ☐ No	Epilepsy or Seizures	☐ Yes / ☐ No	Heart Trouble	☐ Yes / ☐ No
Artificial Joint	☐ Yes / ☐ No	Excessive Bleeding	☐ Yes / ☐ No	Hemophilia	☐ Yes / ☐ No
Asthma	☐ Yes / ☐ No	Excessive Thirst	☐ Yes / ☐ No	Hepatitis A	☐ Yes / ☐ No
Blood Disease	☐ Yes / ☐ No	Fainting Spells	☐ Yes / ☐ No	Hepatitis B or C	☐ Yes / ☐ No
Blood Transfusion	☐ Yes / ☐ No	Fever Blisters	☐ Yes / ☐ No	Herpes	☐ Yes / ☐ No
Breathing Problems	☐ Yes / ☐ No	Frequent Cough	☐ Yes / ☐ No	High Blood Pressure	☐ Yes / ☐ No
Bruise Easily	☐ Yes / ☐ No	Frequent Diarrhea	☐ Yes / ☐ No	High Cholesterol	☐ Yes / ☐ No
Cancer	☐ Yes / ☐ No	Frequent Headaches	☐ Yes / ☐ No	Hives or Rash	☐ Yes / ☐ No
Chemotherapy	☐ Yes / ☐ No	Genital Herpes	☐ Yes / ☐ No	Hypoglycemia	☐ Yes / ☐ No
Chest Pains	☐ Yes / ☐ No	Glaucoma	☐ Yes / ☐ No	Irregular Heartbeat	☐ Yes / ☐ No
Leukemia	☐ Yes / ☐ No	Radiation Treatments	☐ Yes / ☐ No	Kidney Problems	☐ Yes / ☐ No
Liver Disease	☐ Yes / ☐ No	Recent Weight Loss	☐ Yes / ☐ No	Intestinal Disease	☐ Yes / ☐ No
Low Blood Pressure	☐ Yes / ☐ No	Renal Dialysis	☐ Yes / ☐ No	Stomach Disease	☐ Yes / ☐ No
Lung Disease	☐ Yes / ☐ No	Rheumatic Fever	☐ Yes / ☐ No	Stroke	☐ Yes / ☐ No
Mitral Valve Prolapse	☐ Yes / ☐ No	Rheumatism	☐ Yes / ☐ No	Swelling of Limbs	☐ Yes / ☐ No
Osteoporosis	☐ Yes / ☐ No	Scarlet Fever	☐ Yes / ☐ No	Thyroid Disease	☐ Yes / ☐ No
Pain in Jaw Joints	☐ Yes / ☐ No	Shingles	☐ Yes / ☐ No	Tonsillitis	☐ Yes / ☐ No
Parathyroid Disease	☐ Yes / ☐ No	Sickle Cell Disease	☐ Yes / ☐ No	Tuberculosis	☐ Yes / ☐ No
Psychiatric Care	☐ Yes / ☐ No	Sinus Trouble	☐ Yes / ☐ No	Tumors or Growths	☐ Yes / ☐ No
Diabetes	☐ Yes / ☐ No	Spina Bifida	☐ Yes / ☐ No	Ulcers	☐ Yes / ☐ No
Venereal Disease	☐ Yes / ☐ No	Yellow Jaundice	☐ Yes / ☐ No		

Have you ever had any serious illness not listed above? ☐ Yes / ☐ No

If Yes: ____________________

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 the 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: ____________________