Watson Family Dentistry

ADULT REGISTRATION AND MEDICAL HISTORY

Date_____

Date of Birth_____

Full Name_____ Social Security #_____

First Middle Last

Mailing Address_____

Street Address _____ E-mail_____

City_____ State_____ Zip Code_____ Home Phone_____

Employed by_____ How long?_____ Bus. Phone_____

Name of Spouse_____ Employed by_____ Cell Phone_____

If single, parent's name_____

In case of emergency, who should be notified?_____ Phone_____

(Nearest Living Relative Not Living With You)

Person financially responsible_____

Name of Primary dental insurance?_____ Name of Secondary Insurance, if applicable_____

Policy Number and Ins. Holder for Primary_____ Policy Number and Ins. Holder for Secondary_____ Date of Birth for Primary Subscriber_____ Date of Birth for Secondary Subscriber_____

Please list other family members who are patients in this office_____

_____

When were last dental x-rays taken?_____

Name of previous dentist_____

Whom may we thank for referring you?_____

It is important that we know about your dental and medical history. Many things have a direct bearing on dental health. Information you give is strictly confidential.

Your Physician' Name_____ Phone_____

Are you now under the care of a physician?_____ Reason_____

Are you taking any medication?_____ If so, list_____

Have you been hospitalized in the past year?_____ Past 5 years?_____ Year of Hospitalization_____

Are you pregnant?_____ Average/Baseline Blood Pressure_____

Do you have or have you had any of the following? Please indicate with a check mark:

Yes	No		Yes	No		Yes	No	
___	___	Any heart problems*	___	___	High Blood Pressure	___	___	Hepatitis A/B/C
___	___	Heart murmur*	___	___	Low Blood Pressure	___	___	Venereal Disease
___	___	Rheumatic Fever*	___	___	Stroke	___	___	Autoimmune Disorder (AIDS)
___	___	Mitral Valve Prolapse*	___	___	Diabetes	___	___	Tumors or Malignancies
___	___	Heart Valve Replacement*	___	___	Do you take insulin?	___	___	Radiation/Chemo Treatment
___	___	Hip/Knee/Joint Replacement*	___	___	Respiratory Problems	___	___	Kidney Problems
___	___	Orthopedic Surgery*	___	___	Asthma/Emphysema	___	___	Epilepsy
___	___	Allergy to Local Anesthesia	___	___	Tuberculosis	___	___	Nervous Disorders
___	___	Allergy to Penicillin	___	___	Sinus Problems	___	___	Psychiatric Care
___	___	Other Allergies (list)_____	___	___	Bleeding Problems	___	___	Immune Deficiency
		_____	___	___	Liver Problems	___	___	Current or Past Tobacco Use

UPDATES

_____	_____
_____	_____
_____	_____
_____	_____
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_____	_____
_____	_____

Is there anything not listed you think we should know?_____

_____

The following medical conditions may require antibiotic premedication: heart problems, Rheumatic fever, heart murmur, mitral valve prolapse, heart valve replacement, orthopedic surgery, hip/knee/joint replacement, depressed immune system. If you have any of these conditions, please contact this office prior to your appointment so that we may assist you in receiving any necessary premedication. Thank you.