Dental Care Center- Free Dental Day

Harrold, Higgins, Mani, Watson

Patient Registration

Patient Name: ____ Date: ____________
Last, First MI (Preferred Name)

Gender________________________ Marital Status: ___________

Social Security #: ______________________________ Birth Date: ________________ Age: _______

Phone (Home): _____________ (Cell): ______________ email: ___________________________

Address: ____
Street Apartment #

____
City State Zip Code

Health Information

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies ___________ ___________
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes Type____
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis Type____
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:__________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ Latex allergy
- ☐ ________________

- Have you been advised by your physician to pre-medicate prior to dental treatments? ☐ Yes ☐ No

Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: ____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____
- Name of Physician: ______________________________________ Phone: ______________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____
- Please list any medications, including non-prescription drugs, taken on a regular basis________________

____

Are you Currently Employed? ☐ Yes ☐ No **Occupation**:______________________
Do you currently have Dental Insurance? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct.

____ Date: ______________
Signature of patient, parent or guardian

Reviewed by:_______________________________________ Date:__________________

Regarding HIPPA... We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to make you aware of our privacy practices. By signing below you acknowledge that you have received a copy of our HIPAA guidelines. Thank you.

SIGNATURE: ____ **DATE:**__________________

☐ Doctor ______________________________ ☐ RDH______________________________