Harry R. Mack Jr., D.D.S., M.D. / Ryan F. Thomas, D.D.S.

Patient Registration

PATIENT INFORMATION

Name _____ Birth date ___/___/___ Preferred Name _____

Address _____ City _____ State _____ Zip _____

Sex: ❒ M ❒ F ❒ Married ❒ Widowed ❒ Single Social Security Number _____

❒ Separated ❒ Divorced ❒ Minor

Home Phone (___)_____ Cell Phone (___)_____ Work Phone (___)_____ Email _____

Employer/School _____ Employer/School Phone (___)_____

Employer/School Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Birth date ___/___/___ Employer _____ Work (___)_____

Whom may we thank for referring you _____ General Dentist _____

Emergency Contact _____ Phone Number (___)_____

RESPONSIBLE PARTY

Name of Person Responsible for Account (Must be Present to sign) _____ Relation to patient _____

Address _____ Home Phone (___)_____ Birth Date ___/___/___

Employer _____ Work Phone (___)_____ Cell Phone (___)_____

DENTAL INSURANCE INFORMATION

Insurance Company _____ Phone Number _____

Subscriber ID _____ Subscriber's Social _____ Group Number _____

Subscriber's Name _____ Birth Date ___/___/___ Relation to patient _____

SECONDARY DENTAL INSURANCE INFORMATION

Insurance Company _____ Phone Number _____

Subscriber ID _____ Subscriber's Social _____ Group Number _____

Subscriber's Name _____ Birth Date ___/___/___ Relation to patient _____

MEDICAL INSURANCE INFORMATION

Insurance Company _____ Phone Number _____

Subscriber ID _____ Subscriber's Social _____ Group Number _____

Subscriber's Name _____ Birth Date ___/___/___ Relation to patient _____

_____ _____

Signature of Patient/Guardian/Responsible Party Date

MEDICAL HISTORY FORM

Name: _____ Date: _____

Date of Birth: _____ Sex: M / F Height: _____ Weight: _____

For the following questions, circle yes or no. whichever applies Your answers are for our records only and will be kept confidential.

Are you under a physicians care? What for? _____

Please list **ALL** medications you are currently taking (Include any over-the-counter **AND** prescription medication

_____

_____

Family Physician _____ Phone Number _____

Do you need to be pre-medicated with an antibiotic for any reason? _____

Are you presently taking blood thinners (Coumadin, etc.)? No ❑ Yes ❑

Have you had any serious illness, operation, hospitalization within the past 5 year? No ❑ Yes ❑

Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? No ❑ Yes ❑

Have you ever taken any of the following medications for osteoporosis, multiple myeloma, or metastatic bone cancer?
Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia, Xgeva, Avastin No ❑ Yes ❑

Please Check any of the following problems/conditions that apply to you:

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS	❑	❑	Dizziness	❑	❑	HIV Positive	❑	❑	Scarlet Fever	❑	❑
Allergies (Seasonal)	❑	❑	Drug Addiction	❑	❑	HPV (Human Papilloma Virus)	❑	❑	Seizures	❑	❑
Anemia	❑	❑	Emphysema	❑	❑	Jaundice	❑	❑	Sinus Problems	❑	❑
Angina (Chest pain)	❑	❑	Epilepsy	❑	❑	Jaw Joint Pain	❑	❑	Sleep Apnea	❑	❑
Arthritis	❑	❑	Excessive Bleeding	❑	❑	Kidney Disease	❑	❑	Stomach Problems	❑	❑
Artificial Heart Valve	❑	❑	Fainting	❑	❑	Liver Disease	❑	❑	Stroke	❑	❑
Artificial Joints	❑	❑	Glaucoma	❑	❑	Low Blood Pressure	❑	❑	Thyroid Disease	❑	❑
Asthma	❑	❑	Heart Conditions	❑	❑	Mitral Valve Prolapse	❑	❑	Tuberculosis	❑	❑
Blood Disease	❑	❑	Heart Lesions (Congenital)	❑	❑	Nervousness/Depression	❑	❑	Ulcers	❑	❑
Bruise Easily	❑	❑	Heart Murmur	❑	❑	Pacemaker	❑	❑	Venereal Disease	❑	❑
Cancer	❑	❑	Heart Surgery	❑	❑	Pregnant Currently	❑	❑	Osteoporosis	❑	❑
Cervical Cancer	❑	❑	Hepatitis A	❑	❑	Radiation (head/neck)	❑	❑	Other _____		
Chemotherapy	❑	❑	Hepatitis B	❑	❑	Respiratory Problems	❑	❑	_____		
Cortisone Medication	❑	❑	Hepatitis C	❑	❑	Rheumatic Fever	❑	❑	_____		
Diabetes	❑	❑	High Blood Pressure	❑	❑	Rheumatism	❑	❑			

Are you Allergic or have you reacted adversely to any of the following medications?

	YES	NO		YES	NO		YES	NO		YES	NO	
Aspirin	❑	❑	Hydrocodone	❑	❑	Any Metal	❑	❑	Valium	❑	❑	Other _____
Clindamycin	❑	❑	Latex	❑	❑	Codeine	❑	❑	Penicillin	❑	❑	_____
Nitrous	❑	❑	Local Anesthetic	❑	❑	Erythromycin	❑	❑	Sulfa	❑	❑	_____

Have you had any serious trouble associated with previous dental treatment? If so, explain: No ❑ Yes ❑

_____

Do you have any other condition or disease you think the doctor should know about? If so, explain: No ❑ Yes ❑

_____

Do you smoke or chew tobacco? How much? _____ No ❑ Yes ❑

Is there past history of alcohol or chemical dependency or emotional disorder the may affect the care we provide? No ❑ Yes ❑

Are you wearing contact lenses? No ❑ Yes ❑

WOMEN

Are you pregnant or trying to become pregnant No ❑ Yes ❑

Do you have problems associated with your menstrual period? No ❑ Yes ❑

Are you nursing? No ❑ Yes ❑

Are you taking birth control? No ❑ Yes ❑

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Date: _____ Patient's Signature: _____ Doctor's Signature: _____

Assistant's Signature: _____