PATIENT REGISTRATION AND MEDICAL HISTORY

Date____________________ (PLEASE PRINT) Home Phone_________________________

Cell Phone___________________________

E-mail______________________________

Patient____Legal First Name____________________

Last Name Preferred First Name M.I.

Street Address ______________________________Apt#_____City_________State _________Zip ___________

Sex ☐ M ☐ F Age_____________ Birth Date ___________________☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed by _______________________________________Occupation ______________________

Business Address___________________________________Business Phone ____________________________

Spouse Name____

Spouse Employed by _________________________________Occupation ______________________

Spouse Business Address _____________________________Spouse Business Phone______________________

Who is responsible for this account? ___________________________Relationship to Patient _______________________

Name of Dental Insurance Company ___________________________Group Number _______________________

Insured Person Name_______________________________Insured Person's Birth Date____________________

Insured Person's Social Security #_____________________________Patient's Social Security #_____________________

In case of emergency, who should be notified? _____________________Phone Number _______________________

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 boxes that apply):

- ☐ Artificial Heart Valves/Joints
- ☐ Allergies to Medication/Drugs
- ☐ Allergies to Anesthetics
- ☐ Asthma
- ☐ Back Problems
- ☐ Cancer
- ☐ Chemotherapy/Radiation Treatment
- ☐ Coumadin/Blood Thinner
- ☐ Diabetic
- ☐ Epilepsy/ Seizers
- ☐ Excessive Bleeding
- ☐ Heart Conditions/Surgery
- ☐ Heart Pacemaker
- ☐ Hepatitis/Liver Disease
- ☐ High Blood Pressure
- ☐ HIV Positive/AIDS
- ☐ Nervous/Panic Disorder
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Ulcer

1. Are you currently in good health? ☐YES ☐NO
   If "NO", explain____

2. Are you currently taking any medication at this time? ☐YES ☐NO
   If "YES", name of the medications____

3. Do you have any drug allergies or have you ever had an adverse reaction to any mediation? ☐YES ☐NO

   If "YES", name of the drug/medication____

4. Are you currently under care of a physician? ☐YES ☐NO
   If "YES", for what condition? ____

5. (Women Only) Do you suspect that you are pregnant? ☐YES ☐NO Are you nursing? ☐YES ☐NO

6. Is there anything else we should know about your medical history?______________________________

The above Information is accurate and complete to the best of my knowledge and is only for use in my treatment and the billing and processing of insurance claims. I authorize Dr. Baba to perform necessary dental procedures and will not hold him or any member of his staff, responsible for any errors or omissions I may have made in the completion of this form.

Date ____Signature ______________________________________