Acacia
Family Dental

PATIENT REGISTRATION AND MEDICAL HISTORY

Date_____ Cell Phone_____

Patient_____

Last Name First Name Middle Initial Preferred Name

Street Address_____City_____State_____Zip_____

Sex: ☐ M ☐ F Age_____Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed by_____Occupation_____

Business Address_____Business Phone_____

Spouse/Parent Name_____Spouse/Parent Birthdate_____

Spouse/Parent Employed by_____Spouse/Parent Occupation_____

Patient's Social Security #_____Spouse/Parent Social Security #_____

Name of Dental Insurance Company_____Group #_____

In case of emergency, please contact_____Phone_____

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 all that apply)

- ☐ Heart problems
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Circulatory problems
- ☐ Radiation treatment
- ☐ Artificial heart valves or joints
- ☐ Recent weight loss
- ☐ Back problems
- ☐ Diabetes
- ☐ Respiratory disease
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitis, jaundice, or liver disease
- ☐ Cancer
- ☐ Psychiatric care
- ☐ Chronic diarrhea
- ☐ Allergies to anesthetics
- ☐ Allergies to medicine or drugs
- ☐ General allergies
- ☐ Blood disease
- ☐ Arthritis
- ☐ Swollen neck glands
- ☐ Rheumatic fever
- ☐ Sinus problems
- ☐ AIDS or other immunosuppressive disorders
- ☐ Stroke
- ☐ Ulcer
- ☐ Venereal disease
- ☐ Chemical dependency
- ☐ Hemophilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____If so, what medication_____

Have you ever responded adversely to medical or dental treatment?_____

Are you taking any medication at this time? _____If so, what_____

Are you under the care of a physician? ☐ Yes ☐ No

For what conditions? _____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Is there anything else we should know about your medical history? _____

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TREATMENT CONSENT

I certify that the above information is accurate and completed to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I understand that providing incorrect and/or inaccurate information may be hazardous to my health. I will inform the office of any health changes at my next appointment.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payer, and/or healthcare practitioners. I authorize my insurance carrier to submit payment directly to the dentist or dental practice.

I authorize Acacia Family Dentistry to take photographs of my face, jaws, and teeth. I understand that these photographs will be used as a record of my care and for professional communications, and that these photos may be used for educational purposes, advertising, or professional publication without revealing my identity.

Date_____ Signature_____