# Patient Registration Update

Name_____ Birthdate_____ Age_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Email Address_____

Circle preferred method for confirming appointments: Home Work Cell Email Text

Emergency Contact…Name & Phone Number_____

## Medical History…do you have or have you ever had any of the following?

- ☐ Alzheimer's/Dementia
- ☐ Anemia
- ☐ Blood Disorder Type_____
- ☐ Cancer Type_____
- ☐ Headaches
- ☐ Stroke(s)
- ☐ High/Low Blood Pressure
- ☐ Heart Conditions Type_____
- ☐ Heart Valve Replacement Date_____
- ☐ Pacemaker Type & Date_____
- ☐ Hepatitis Type_____
- ☐ Diabetes Type_____
- ☐ Herpes Simplex… Type _____
- ☐ HPV (Human Papillomavirus)
- ☐ HPV Vaccination
- ☐ Pregnant
- ☐ Nursing
- ☐ Taking Hormones
- ☐ AIDS/HIV
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Epilepsy, Fainting, Seizures
- ☐ Sjogren's
- ☐ Thyroid Problem
- ☐ Asthma
- ☐ Respiratory Problems
- ☐ Tuberculosis
- ☐ Anxiety
- ☐ Depression
- ☐ Eating Disorder
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Surgery(s)
- ☐ Acid Reflux/GERD
- ☐ Excessive Bleeding/Bruising
- ☐ Sleep Apnea/Disorder Treatment_____
- ☐ Artificial Joint or Heart Valve Replacement… Type and Date_____ _____ _____
- ☐ Allergy to Anesthetics
- ☐ Allergy to Latex/Rubber
- ☐ Allergy to Metals
- ☐ Allergy to Fluoride
- ☐ Allergy to Medication(s) Please list… _____ _____ _____
- ☐ Alcohol Use Frequency_____
- ☐ E-Cig/Vaping/Tobacco/ Marijuana…Type & Frequency _____

Do you need Pre-medication with an antibiotic prior to your dental visit? Yes or No

Please list all current prescription and over-the-counter medications and supplements…

_____

_____

Are there any other medical conditions that may possibly affect your dental treatment? Yes or No **If** yes please describe _____

_____

**Signature** _____ **Date** _____