

## North University Dental Associates Patient Registration Form

ID: \_\_\_\_\_

Chart ID: \_\_\_\_\_

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_

Patient Is:  Policy Holder  Responsible Party

Preferred Name: \_\_\_\_\_

Responsible Party ( if someone other than the patient ) \_\_\_\_\_

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Ext: \_\_\_\_\_

Cellular: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Soc Sec: \_\_\_\_\_

Drivers Lic: \_\_\_\_\_

 Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

### Patient Information

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_

State / Zip: \_\_\_\_\_

Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Ext: \_\_\_\_\_

Cellular: \_\_\_\_\_

Sex:  Male FemaleMarital Status:  Married Single Divorced Separated Widowed

Birth Date: \_\_\_\_\_

Age: \_\_\_\_\_

Soc Sec: \_\_\_\_\_

Drivers Lic: \_\_\_\_\_

E-mail: \_\_\_\_\_

 I would like to receive correspondences via e-mail.

### Section 2

### Section 3

Employment Status:  Full Time Part Time Retired

Emergency Contact \_\_\_\_\_

Emergency # \_\_\_\_\_

Cell phone \_\_\_\_\_

Student Status:  Full Time Part Time

Medicaid ID: \_\_\_\_\_

Pref. Dentist: \_\_\_\_\_

Employer ID: \_\_\_\_\_

Pref. Pharmacy: \_\_\_\_\_

Carrier ID: \_\_\_\_\_

Pref. Hyg: \_\_\_\_\_

### Primary Insurance Information

Name of Insured: \_\_\_\_\_

Relationship to Insured:  Self Spouse Child Other

Insured Soc. Sec: \_\_\_\_\_

Insured Birth Date: \_\_\_\_\_

Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_

Rem. Deduct: \_\_\_\_\_

### Secondary Insurance Information

Name of Insured: \_\_\_\_\_

Relationship to Insured:  Self Spouse Child Other

Insured Soc. Sec: \_\_\_\_\_

Insured Birth Date: \_\_\_\_\_

Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_

Rem. Deduct: \_\_\_\_\_

**Medical History**

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, can affect your dental health.

Are you under a physician's care now?	<input type="radio"/> Yes <input type="radio"/> No	If yes <input type="text"/>
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes <input type="text"/>
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes <input type="text"/>
Do you take any blood thinners?	<input type="radio"/> Yes <input type="radio"/> No	If yes <input type="text"/>
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="radio"/> Yes <input type="radio"/> No	If yes <input type="text"/>
Are you taking any other medications, pills, or drugs?	<input type="radio"/> Yes <input type="radio"/> No	If yes <input type="text"/>
Have you ever been told to take an antibiotic prior to dental treatment?	<input type="radio"/> Yes <input type="radio"/> No	If yes <input type="text"/>
Do you smoke?	<input type="radio"/> Yes <input type="radio"/> No	If yes <input type="text"/>
Do you use any other form of tobacco?	<input type="radio"/> Yes <input type="radio"/> No	If yes <input type="text"/>
Do you have dental anxiety?	<input type="radio"/> Yes <input type="radio"/> No	If yes <input type="text"/>
Do you require any additional assistance getting in and out of the dental chair?	<input type="radio"/> Yes <input type="radio"/> No	If yes <input type="text"/>
Have you ever been treated for alcohol or substance abuse?	<input type="radio"/> Yes <input type="radio"/> No	If yes <input type="text"/>

Women: Are you...

Pregnant/Trying to get pregnant?  Nursing?  Taking oral contraceptives?

Are you allergic to any of the following?

<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Metal	<input type="checkbox"/> Latex
<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Local Anesthetics		

Do you have any other allergies not listed above?  If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No	Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No
Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No	Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No
Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No	Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema/COPD	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
Rheumatism	<input type="radio"/> Yes <input type="radio"/> No	Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No
Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No	Breathing Problems	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No
Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No	Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No
Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No
Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No	Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No	Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No
Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No
Acid Reflux	<input type="radio"/> Yes <input type="radio"/> No	Sleep Apnea	<input type="radio"/> Yes <input type="radio"/> No	Eating Disorder	<input type="radio"/> Yes <input type="radio"/> No		

Have you ever had any serious illness not listed above?  Yes  No If yes

Comments:

<input type="text"/>
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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: \_\_\_\_\_