HARBOR DENTAL™

Patient Registration Form

PATIENT INFORMATION

Patient Name: (Last, First, MI, Preferred Name)

Gender: ☐ Male ☐ Female

Family Status: ☐ Married ☐ Single ☐ Child ☐ Other

Birth Date:

Last Dental Visit:

Email Address:

Phone: (Mobile, Home, Work)

Address:

Preferred Appointment Times: (Mon, Tue, Wed, Thur, Fri, Morning, Afternoon)

Name of person, office, or other source referring you to our practice:

RESPONSIBLE PARTY (IF NOT PATIENT)

The Following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Gender: ☐ Male ☐ Female

Family Status: ☐ Married ☐ Single ☐ Child ☐ Other

Name:

Date of Birth:

Address:

Phone: (Mobile, Home, Work)

Email Address:

EMPLOYMENT INFORMATION

Employer Name:

Phone:

Address: (Street, City, State, ZIP)

MEDICAL HISTORY

Are you in good health: ☐ Yes ☐ No

Has there been a change in your health in the past year? ☐ Yes ☐ No

If yes, please explain:

When was your last physical examination?

Name and Address of your physician:

Are you currently being treated for any medical conditions? ☐ Yes ☐ No

If so, what medical conditions are you being treated for?

Are you currently taking any medications Prescription or Non-Prescription? ☐ Yes ☐ No

If you are taking any medications, list here:

Do you have or have you had any of the following diseases or problems?

- ☐ Damaged Heart Valves
- ☐ Cardiovascular Disease
- ☐ Allergy
- ☐ Sinus Trouble
- ☐ Asthma or Hay Fever
- ☐ Fainting Spells or Seizures
- ☐ Persistent Diarrhea or Recent Excess Weight Loss
- ☐ Diabetes
- ☐ Hepatitis, Jaundice, or Liver Disease
- ☐ AIDS or HIV Infection
- ☐ Thyroid Problems
- ☐ Respiratory Problems, Emphysema, Bronchitis, etc...
- ☐ Arthritis or Painful Swollen Joints
- ☐ Stomach Ulcer or Hyperacidity
- ☐ Kidney Trouble
- ☐ Tuberculosis
- ☐ Persistent Cough or Cough that Produces Blood
- ☐ Persistent Swollen Glands in Neck
- ☐ Low Blood Pressure
- ☐ Sexually Transmitted Disease
- ☐ Epiliepsy or other Neurological Disease
- ☐ Problems with Mental Health
- ☐ Cancer
- ☐ Problems with Immune System
- ☐ Blood Disorder such as anemia
- ☐ Treatment for Tumor or Growth
- ☐ Cold Sores
- ☐ Pain in Jaw Joint
- ☐ Drug Addiction
- ☐ History of Excessive Bleeding that has required treatment

Any Details of Diseases or Problems From the Previous Question:

MEDICAL HISTORY (CONTINUED)

Do you Have Any Artificial Joints? ☐ Yes ☐ No

If so, what joints are artificial and when were they placed?

Are you Allergic or Have You Had a Reaction to:

☐ Local Anesthetics

☐ Penicillin or other Antibiotics

☐ Sulfa Drugs

☐ Barbituates, Sedatives or Sleeping Pills

☐ Aspirin or NSAIDS

☐ Codiene or Other Narcotic

OTHER

Any Details to Previous Allergy/Reaction Question:

Have You Had Any Serious Trouble Associated With any Previous Dental Treatment? ☐ Yes ☐ No

If so, explain:

Do you have any disease, condition, or problem not listed above that you think I should know about?

Do you currently use or have you been a tobacco user in the past? ☐ Yes ☐ No

Do you use alcoholic beverages? ☐ Yes ☐ No

If so, how often?

Is There Anyting You Would Like To Change About Your Smile? ☐ Yes ☐ No

If so, what?

WOMEN

Are you Pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No