Gentle Family Dentistry **(please fill out the front only)**

Adult Patient Registration and Medical History

Patient Information:

____
(last name) (first name) (middle initial) (preferred name)

Address:____

City:__________________________________ State:_______________ Zip:_______________

Home phone: ___________________________ Cell Phone: ______________________________

Employed by: ______________________________ Occupation: __________________________

Business address: ___________________________City, State, Zip: ___________________________

Business phone: ___________________________ Social Security No.: ___________________________

Email Address: ___________________________ May we contact you via email? _______________

Sex: M F Date of birth: _____________________ Marital status: single married widowed divorced

Spouse's Information:

____
(last name) (first name) (middle initial)

Spouse employed by: ___________________________ Occupation: ___________________________

Business address: ___________________________ City, State, Zip: ___________________________

Business phone: ______________________ Social Security No: ___________________________

In case of an emergency, who should we contact: ___________________________

Relationship to patient: ______________________ Phone No: ______________________

Whom may we thank for referring you? ___________________________

Medical History:

Physician's name: ______________________Phone #:_______________Last physical exam:__________

Have you ever had any of the following: (check all boxes that apply)

__ Heart problems
__ High blood pressure
__ Low blood pressure
__ Circulatory problems
__ Nervous problems
__ Radiation treatment
__ Artificial heart valve
__ Pace maker
__ Joint Replacement
__ Back problems
__ Diabetes

__ Headaches
__ Hepatitis (circle A, B, C)
__ Jaundice
__ Cancer
__ Allergies to medications/drugs
__ Allergies to anesthetics
__ General Allergies
__ Blood disease
__ Respiratory disease
__ Epilepsy/convulsions
__ Asthma

__Arthritis
__ Kidney disease
__ Liver disease
__ Abnormal bleeding
__ Cosmetic/plastic surgery
__ Heart murmur
__ Mitral valve prolapse
__ Swollen neck glands
__ Rheumatic fever
__ Sinus problem
__ Stroke
__ Parkinson's Disease

__Latex Allergy
__ Ulcer
__ Venereal disease
__ Chemical dependency
__ Hemophilia
__ Tuberculosis
__ Sleep apnea/snoring
__ Recent weight loss
__ Bone density medication
__ HIV, AIDS, or other immunosuppressive disorder
__ Psychiatric care

Any recent operations? (please list)____

Any disabilities? (please list)____

Drug allergies or adverse reactions (please list)____

Currently under a physician's care? (please explain)____

Currently taking any medications or supplements (please list)____

Women – Do you suspect you are pregnant?_______________ Are you nursing? ___________________________

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

The above information is accurate & complete to the best of my knowledge & is only for use in my treatment, billing, & processing of insurance. I will not hold my dentist or any member of the dental staff responsible for any errors or omissions that I may have made in completion of this form.

Signature:____ **Date:**_______________________