ROCKY RIVER DENTAL
REGISTRATION FORM

Today's date:

PATIENT INFORMATION					
Patient's Name:		❑ Mr. ❑ Ms ❑ Mrs. ❑ Dr.	❑ Male ❑ Female	Marital Status (circle one): Single / Married / Div / Sep / Wid	Student ❑
Birth Date:	Social Security No:	Email address:			Home Phone:
Street Address:	City	State	Zip		Mobile Phone:
Employer:	Position:				How long held:
Employer Street Address:	City:	State:	Zip:		Work Phone:
Responsible payor if minor:	Birth Date:	Social Security No:			
Name of Spouse:	Birth Date:	Social Security No:			
Spouse's Employer:		Work Phone:			How long held:
Name of relative (not living at same address):	Relationship to patient:	Home Phone:			Work Phone:
Who may we thank for referring you?		Known from:			

INSURANCE INFORMATION			
(Federal and state regulations require that you report all dental and medical insurance coverage under which you may be eligible for benefits. Failure to do so will result in the cancellation of benefits under all policies.)			
Dental Insurance Company #1:	Address:		Phone:
Policy # or ID:	Group #:	❑ Individual Plan	❑ Family Plan (coverage for spouses and children)
Dental Insurance Company #2:	Address:		Phone:
Policy # or ID:	Group #:	❑ Individual Plan	❑ Family Plan (coverage for spouses and children)

MEDICAL HISTORY		
For the following questions, circle "yes" or "no", whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit, you may be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.		
1. Are you in good health?	YES	NO
2. Has there been any change in your general health within the past year?	YES	NO
3. Are you now under the care of a physician?	YES	NO
4. Have you had any serious illness, operation, or been hospitalized in the past five years?	YES	NO
5. Have you had abnormal bleeding?	YES	NO
6. Do you have any blood disorder, such as anemia?	YES	NO
7. Are you wearing removable dental appliances?	YES	NO
8. Have you ever had any treatment for a tumor or growth?	YES	NO
9. Have you had any serious trouble associated with previous dental treatment?	YES	NO
10. Are you wearing contact lenses?	YES	NO

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11. Are you taking any medicine(s) including nonprescription medicine? If so, list medicine(s) below.	YES	NO

Drug	Reason	Drug	Reason
_____	_____	_____	_____
_____	_____	_____	_____

12. Are you allergic or have you had a reaction to:

a. Local anesthetics	YES	NO	d. Aspirin	YES	NO
b. Penicillin	YES	NO	e. Codeine or other narcotics	YES	NO
c. Barbiturates, sedatives or sleeping pills	YES	NO	f. Other known drug allergies:		

13. Do you have any diseases, conditions, surgeries or problems that you think I should know about? If so, please explain: _____	YES	NO

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

a. Artificial hip, knee, elbow, other	YES	NO	l. AID or HIV infection	YES	NO
b. Damaged heart valves or artificial heart valves	YES	NO	m. Thyroid problems	YES	NO
c. Heart murmur or Rheumatic heart disease	YES	NO	n. Respiratory problems, emphysema, bronchitis,.etc.	YES	NO
d. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis)	YES	NO	o. Arthritis or painful swollen joints	YES	NO
			p. Stomach ulcer or hyper acidity	YES	NO
1) Do you have chest pain upon exertion	YES	NO	q. Kidney trouble	YES	NO
2) Are you ever short of breath after mild exercise or when lying down	YES	NO	r. Tuberculosis	YES	NO
3) Do your ankles swell	YES	NO	s. Persistent cough or cough that produces blood	YES	NO
4) Do you have inborn heart defects	YES	NO	t. Persistent swollen glands in neck	YES	NO
5) Do you have a cardiac pacemaker	YES	NO	u. Low blood pressure	YES	NO
e. Allergy	YES	NO	v. Sexually-transmitted disease	YES	NO
f. Sinus trouble	YES	NO	w. Epilepsy or other neurological disease	YES	NO
g. Asthma or hay fever	YES	NO	x. Problems with mental health	YES	NO
h. Fainting spells or seizures	YES	NO	y. Cancer	YES	NO
i. Persistent diarrhea or recent weight loss	YES	NO	z. Problems of the immune system	YES	NO
j. Diabetes	YES	NO	aa. Do you smoke or use smokeless tobacco?	YES	NO
k. Hepatitis, jaundice or liver disease	YES	NO			

15. Physician name:	Address:	Last physical exam:
16. Previous dentist:	Address:	Last visit date:

17. Chief dental complaint:

WOMEN ONLY

18. Are you pregnant?	YES	NO	20. Are you nursing?	YES	NO
19. Do you have any problems associated with your menstrual period?	YES	NO	21. Are you taking birth control pills?	YES	NO

I certify that I have read and understand the above, I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other members of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES AND ANY SPECIAL HANDLING FEES OR SERVICE CHARGES INCURRED BY A COLLECTION AGENCY, INCLUDING COURT COSTS AND LEGAL FEES WHETHER OR NOT PAID BY INSURANCE.**

Signature of person responsible _____ Date _____

For completion by the dentist. Comments on patient interview concerning medical history and/or significant findings: _____

_____

_____

Dentist's Signature _____ Date _____