PATIENT REGISTRATION AND MEDICAL HISTORY

Date | Home Phone

Patient Information

Last Name | First Name | Middle Initial

Street Address | City | State | Zip

E-mail Address | Cell Phone

Sex | Age | Birthdate | Relationship Status

Employer/School | Occupation

Employer/School Address | Employer/School Phone

Spouse/Parent Name | Spouse/Parent Birthdate

Spouse/Parent Employed By | Occupation

Business Address | Business Phone

Who is responsible for this account? | Relationship to Patient

Social Security # | Spouse/Parent Social Security #

In case of emergency, who should be notified? | Phone

Whom may we thank for referring you?

Insurance Information

Name of Dental Insurance Company | Group #

Medical Information

Physician's Name _____ Date of Last Physical _____

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

- ☐ Allergies
- ☐ Arthritis
- ☐ Artificial Heart Valves or Joints
- ☐ Back Problems
- ☐ Bleeding Adnormally
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chronic Diarrhea
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems Problems
- ☐ Hemophilia Abnormally
- ☐ Hepatitis or Jaundice
- ☐ Hernia Repair
- ☐ High Blood Pressure
- ☐ HIV/AIDS Diarrhea
- ☐ Low Blood Pressure
- ☐ Mitral Valve Heart Lesions
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychmatric Care
- ☐ Radiation Treatment
- ☐ Recent Weight Loss
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Neck Glands
- ☐ Ulcer
- ☐ Venereal Disease

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia?

☐ Yes ☐ No

If so, what? _____

Are you taking any medication at this time? _____ If so, what? _____

Have you ever responded adversely to medical or dental treatment? ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "faraphen?" These include combinations of Ionimin , Adipex, FastIn (brand names of Phentermine), Pondimin (fenfluramine) and Redux (dexferamine)

☐ Yes ☐ No

If patient is a child, what is his/her weight? _____

Are you under the care of a physician? ☐ Yes ☐ No If so, what? _____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Due Date _____

Are you nursing? ☐ Yes ☐ No Taking Birth Control? ☐ Yes ☐ No

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

You can e-mail this form to Dr. Jennings staff by using the Windows XPS Document Writer option in your printer settings. This will create a Windows XPS file. Simply create the file and e-mail it to Jennings@JenningsFamilyDentistry.com. You can also fill out the form and print it at home to bring with you on your visit to our office.

Print Form