# PATIENT REGISTRATION FORM

ALERT MEDICAL:

NAME: MR/MISS/MRS/MS/DR

_____

DATE OF BIRTH (DAY/MONTH/YEAR) ___/___/____

ADDRESS (HOME):

_____

_____

HOME PHONE: _____

BUSINESS PHONE: _____

CELL PHONE: _____

EMAIL: _____

OCCUPATION: _____

WHO REFFERED YOU TO OUR OFFICE?

_____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME: _____

RELATIONSHIP: _____

DAY-TIME PHONE: _____

NAME OF FAMILY DOCTOR: _____

PHONE OR ADDRESS_____

_____

(1) NAME OF MEDICAL SPECIALIST:_____

AREA OF SPECIALITY: _____

PHONE OR ADDRESS: _____

(2) NAME OF MEDICAL SPECIALIST:_____

AREA OF SPECIALITY: _____

PHONE OR ADDRESS: _____

To receive treatment in this office you must answer all questions on this registration and medical/dental history forms. The questions asked related directly to the safe and effective treatment you are to receive in this office – to the best of ability, honest answers must be given. If you are unsure of the questions, unsure of the answer, or whether the question relates to your medical condition, you are to discuss the matter with the doctor. Some of the questions may not relate to your medical condition; in that event you are to write "N/A" (not applicable) in the space provided. All questions must be answered. To properly evaluate your current health status, it may be necessary for the dentist to contact other health professionals. Included in this for is "Permission to Obtain and Release Information".

Please Sign: _____ Date: _____

All information you supply on this form, and subsequent information from the interview by the dentist and anything received from your physician or any other source, will be held in the strictest confidence and will not be disclosed without your permission.