

Gainesville Family Dental Center
Patient Registration and Medical History

Date: _____ Home Phone: _____ Cell Phone: _____

***Primary language: _____ English _____ Spanish Work Phone: _____

Who may we thank for referring you? _____

Patient: _____
LAST NAME FIRST MIDDLE INITIAL (PREFERRED NAME)

Street Address: _____ City: _____ ST: _____ Zip: _____

Sex: _____M _____F Age: _____ Birth date: _____ Single: _____ Married: _____ Separated: _____

SSN: _____ Employed by: _____

Spouse/Parent Name: _____ Birth date: _____

Spouse/Parent SSN: _____ Name of Insured: _____ Relation to Patient: _____

Who is responsible for this account? _____ Relation to Patient: _____

Birth Date: _____ SSN: _____

When was your last dental visit? What treatment did you receive? _____

Who should we call in case of an emergency? _____ Phone #: _____

Physician's Name: _____ Last Physical: _____

Do you need Pre-medication? _____ Are you taking medication at this time? _____

Are you under the care of a physician? Why? _____

Do you suspect that you may be pregnant? _____ Due Date: _____

Are you taking birth control? _____ (Certain medications may interfere with contraceptives)

Have you ever had any of the following? (CHECK ALL EITHER YES OR NO)

N		Y		N		Y		N		Y		LIST OF MEDS	
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The above information is accurate and complete to the best of my knowledge. Since a change in medical condition or medication can affect dental treatment, I will inform the office of any changes at any subsequent appointment. I will not hold the dentist or any member of his/her staff responsible for any errors of omissions that I might have in completing this form.

Signature of Patient/Parent/Guardian

Date

Doctors Signature

Date