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 (PERFERRED 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
		Diabetes			Glaucoma			Rheumatic Fever	
		Heart Murmur			Kidney Disease			Asthma	
		Artificial Heart Valves			Epilepsy			Ulcer	
		Pacemaker			Headaches			Stroke	
		Mitral Valve Prolapse			Hepatitis/Jaundice			Respiratory Disease	
		Heart Disease			HIV/AIDS/Arc			Sinus Problems	
		Excessive Bleeding			Blood Disease			Swollen Neck Glands	
		Blood Thinners			Venereal Disease			Arthritis	
		Low Blood Pressure			Tuberculosis			Mental Disorders	
		High Blood Pressure			Allergy to Anesthetic			Psychiatric Care	
		Hemophilia			Allergy to Medicine			Chemical Dependency	
		Circulatory Problems			Allergy to Penicillin			Dizziness	
		Radiation Treatment			Allergy to Tetracycline			Thyroid Problems	
		Cancer			Allergy to Latex			Hx of Tobacco Use	
		Joint Replacement			General Allergies			Hx of Osteoporosis	

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