TIME 10:20 AM

DATE 7/18/2016

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Emerg Contact Name

Emerg Contact Number

Contact Relationship

Referred by

Last Dental Appt

Last Dentist

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Time 8:33 AM | North Jacksonville Complete Dentistry | Date 5/9/2023

THE MEDICAL HISTORY FORM!!

Patient Name: | Birth Date: | Date Created:

It is our duty to obtain proper information about your health and medical history. This allows us to properly treat you and to ensure that you are recieving the safest and most predictable care poss

Do you have a primary care physician? Primary Care Physician's Name?	Yes No	If yes	
In the past 5 years, have you been hospitalized or had a major operation? If so, what?	Yes No	If yes	
Taking any medications? Please list the medications that you are taking	Yes No	If yes	
Do you have jaw pain, frequent headaches, or head/neck pain? If so, explain	Yes No	If yes	
Have you taken Fosamax, Boniva, Reclast, Xgeva, Actonel, or any other medications containing bisphosphonates?	Yes No	If yes	
Are you pregnant, trying to get pregnant, or nursing?	Yes No		
Do you use tobacco? If so, what type and quantity?	Yes No	If yes	

Are you allergic to any of the following?

Acrylic	Yes No		
Penicillin	Yes No		
Metals	Yes No		
Local Anesthetics	Yes No		
Latex	Yes No		
Any other allergies not listed? If so, please list	Yes No	If yes	

Do you have, or have you had any of the following?

AIDS/HIV Positive	Yes No	Cortisone Medication	Yes No	Hemophelia	Yes No
Diabetes	Yes No	Alzheimer's Disease	Yes No	Hepatitis A	Yes No
Anaphylaxis	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Rheumatic Fever	Yes No	Emphysema	Yes No
High Blood Pressure	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No
Scarlet Fever	Yes No	Artificial Heart Valve	Yes No	Artificial Joint	Yes No
Hypoglycemia	Yes No	Sickle Cell Disease	Yes No	Asthma	Yes No
Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Troubles	Yes No
Frequent Cough	Yes No	Kidney Problems	Yes No	Leukemia	Yes No
Stomach/Intestinal Disease	Yes No	Breathing Problems	Yes No	Frequent Headaches	Yes No
Liver Disease	Yes No	Stroke	Yes No	Low Blood Pressure	Yes No
Psychiatric Care	Yes No	Angina / Chest Pains	Yes No	Osteoporosis/Osteopenia	Yes No
Cancer/Tumor	Yes No	Active Tuberculosis	Yes No	Radiation Therapy	Yes No
Autoimmune Disease	Yes No	Pacemaker	Yes No	Congestive Heart Failure	Yes No
Parathyroid Disease	Yes No				

Please describe any impending operations, recent injuries, or other information the dentist should be aware of:	Yes No	If yes	

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____