Patient Registration and Medical History

(Please Print)

Date:_______________ Sex: ___Female ___Male Age: ______________

Patient:____ Birthdate:______________________________

Patient's Address:____ Home Phone: (___)______________

City:______________________________ State:__________ Zip:___________ Alternate Phone: (___)______________

Responsible Party:___________________________________ Relationship:______________________________

Street Address: ____ Home Phone: (___)______________

City:______________________________ State:__________ Zip:____________ Alternate Phone: (___)______________

Insurance Provider:___________________ Subscriber:_________________________ Employer:____________________________

Relationship:________________________ Insurance ID#:________________________ Group #:__________________________

Subscriber's Social Security #:___________________________ Subscriber's D.O.B:_____________________________________

MEDICAL HISTORY

Physician:____ Date of last Physical:____________________________

Physician's Contact Phone number: (____)________________________

Do you have or had any of the following Medical Conditions? (select all that apply)

__ **Allergies**
__Arthritis
__**Artificial Heart Valves/Joints**
__Alzheimer's
__Back Problems
__Abnormal Bleeding
__Blood Disease
__Cancer
__Cerebral Palsy
__Chemical Dependency
__Chronic Diarrhea
__Circulatory Problems
__Congenital Heart Lesions
__COPD
__ Dementia
__ Diabetes (type): I or II
__ Epilepsy
__ Headaches
__ **Heart Attack**
__ **Heart Problems**
__ Hemophilia
__ Hepatitis/Jaundice or Liver Disease
__ Hernia Repair
__ High Blood Pressure
__ HIV/AIDS
__ Low Blood Pressure
__ Lymphedema
__ Muscular Dystrophy
__ **Mitral Valve Prolapse**
__ Multiple Sclerosis
__ Nervous Problems
__ Pacemaker
__ Psychiatric Care
__ Radiation Treatment
__ Recent Weight Loss
__ Respiratory Disease
__ Rheumatic Fever
__ Sinus Problems
__ Special Diet
__ Stroke
__ Swollen Neck Glands
__ Other: ___________________

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

__ YES__ NO If yes, please specify: ____

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Are you taking any blood thinners (including aspirin)? __ YES__ NO If yes, please specify: ____________________________

Do you have any metal (pins/plates/rods/screws) or replacement parts (joint or heart valve replacement) in your body?

__YES __NO If yes, please specify: ____

Have you been required to pre-medicate in the past for dental treatment? __YES __NO

Are you allergic to Latex __YES __NO When was your last dental treatment? ______________________________________

Are you Bedridden? __YES __NO Do you have trouble swallowing? __YES __NO

Do you have difficulty with communicating? __YES __NO Do you experience uncooperative behaviors? __YES __NO

List all medications you are currently taking (continue on the back of this form if necessary or attach list): ______________________

____

I herby authorize Dr. Louay Mansour to provide dental treatment to the above named patient.

Patient or Responsible Party's Signature: ____ Date: ___________________