PATIENT REGISTRATION AND MEDICAL HISTORY FORM

Patient's Full Name:________________________________ circle----> Male Female

Mailing Address:____________________ City:__________ State:________ Zip:________

Marital Status: circle----> M S W D Birth Date:____________ S.S.#____________

Phone #:____________________ Spouse's Name:____________________

Spouse's Birth Date:____________________ Spouse's S.S.#____________________

Person responsible for account: circle----> Self Spouse Parent* Other*

*If parent or Other, please list name, address, employer, phone #, S.S.#, birth date, and insurance on the back of this sheet.

Your Employer: Name:____________ Address:____________

Phone:____________ Position:____________

Spouse's Employer: Name:____________ Address:____________

Phone:____________ Position:____________

Where may we leave a message: circle----> Home Work Other____________

Primary Dental Insurance Company:____________________

Carrier (Family Member)____________________ I.D. #____________

Secondary Dental Insurance Company:____________________ I.D. #____________

Carrier (Family Member)____________________

Referring Dentist:____________________ How long have you been his/her patient?____________

Is this Appointment for: circle----> Consultation Treatment

Have you been a patient at Dr.. Skoner's before? circle----> No Yes----> When____________

PERMISSION FOR X-RAYS, CONSULTATION AND/OR ROOT CANAL PROCEDURES

To the best of my knowledge, all answers on this form are correct. I will notify the doctor of any changes in my health or medications.

I, the undersigned, consent to the dental procedures decided upon to be necessary or advisable in the opinion of the doctor, of which I am informed and to which I agree.

I also understand that only the root canal treatment is to be completed at this office. The permanent (outside) restoration (filling, inlay, crown, etc.) will be performed by my general dentist.

SIGNATURE:________________________________ Date:____________________

Please continue to next page--------------------------------->

Your Medical Doctor: ______________________________

Have you been under medical treatment during the past 2 years? circle ------> Yes No
If yes, explain:

____

List any medications or oral contraceptives you are now taking:

____

Are you pregnant or nursing? circle ------> Yes No

HAVE YOU EVER HAD:

Heart Failure	Y	N	Tuberculosis	Y	N
Heart Disease or Attack	Y	N	Asthma	Y	N
Angina Pectoris	Y	N	Allergies or Hives	Y	N
Congenital Heart Diseases	Y	N	Sinus Problems	Y	N
Heart Murmur	Y	N	Radiation Therapy for Cancer	Y	N
Heart Pacemaker	Y	N	Chemotherapy	Y	N
Heart Surgery	Y	N	Hepatitis A (infectious)	Y	N
Mitral Valve Prolapse	Y	N	Hepatitis B (serum)	Y	N
Artificial Heart Valve	Y	N	Venereal Disease	Y	N
Rheumatic Fever	Y	N	A.I.D.S.	Y	N
High Blood Pressure	Y	N	H.I.V. Positive	Y	N
Low Blood Pressure	Y	N	Hemophilia	Y	N
Stroke	Y	N	Anemia	Y	N
Cortisone Medication	Y	N	Sickle Cell Disease	Y	N
Drug Addiction	Y	N	Liver Disease	Y	N
Pain in Jaw Joints	Y	N	Yellow Jaundice	Y	N
Artificial Joints (hip, knee, etc.)	Y	N	Epilepsy or Seizures	Y	N
Kidney Disease	Y	N	Fainting or Dizzy Spells	Y	N
Diabetes	Y	N	Nervousness	Y	N
Thyroid Disease	Y	N	Psychiatric Treatment	Y	N
Do you smoke (use tobacco products)	Y	N	Do you take Aspirin or Ibuprofen (Advil) daily	Y	N

Are you allergic to (circle) Aspirin ------> Yes No Codeine ------> Yes No Penicillin ------> Yes No

Erythromycin ----> Yes No Novocaine ----> Yes No Tetracycline ----> Yes No Latex ----> Yes No (rubber gloves)

Clindamycin ----> Yes No

Are you allergic to anything else?

____

Please explain anything else we should know about your medical history.

____

SIGNATURE: ______________________________ DATE: ______________

Please continue to the next page------------------------->