PATIENT REGISTRATION

MP Dental and Associates PC

Date _____

Patient Name _____ Birthdate _____ Age_____
First Middle Last

SS#_____DL#_____ Occupation _____Work # (___)_____

Marital Status: Single___ Married___ Divorced___ Widowed___ Spouses Name:_____ Work # (___)_____

Home Address_____ Zip _____

Home Number (___)_____ Cell Phone (___)_____ Pager #(___)_____

Fax #(___)_____ E- Mail Address _____

Employer Name and Address _____

Person Responsible for Account_____Relationship _____

Social Security # _____DL#_____Home # (___)_____

Home Address (if different)_____Zip_____

Employer & Address_____

Occupation_____Work # (___)_____

Referred By_____Physician_____

Do you have Dental Insurance? Yes No_____ With Whom?_____

Nearest Relative Not Living With You_____Relationship_____

Address_____Zip_____Phone_____

Are you currently having dental problems?_____

_____

What are your concerns? *Circle as many as applicable:* (Pain Avoidance) (Appearance) (Losing Teeth) (Gum/Periodontal Disease) (Cavities) (Oral Cancer) (Wasting/Exceeding Dental Insurance Limits) (Your General Health) (Routine Checkup) (Cleaning) (Other_____ _____)

Circle yes or no to the following questions:

1. Are you presently under the care of a physician? ..... Yes No
2. Have you ever had high blood pressure? ..... Yes No
3. Has a physician ever said you had heart trouble? ..... Yes No
4. Do you have Mitral Valve Prolapse? ..... Yes No
5. Have you ever had abnormal bleeding following a cut or extraction? ..... Yes No
6. Have you ever had an anesthetic (either local or general)? ..... Yes No
7. Has a physician or dentist ever said you had a tumor or cancer? ..... Yes No
8. Are you allergic to Penicillin, Novocain or any other medicine? ..... Yes No
   If so, what? _____
9. Is the patient allergic to anything other than medicine? (e.g. latex or metals)? ..... Yes No
   If so, what? _____

Do you have or ever had:

1. Rheumatic fever? ..... Yes No
2. Rheumatic heart disease? ..... Yes No
3. Anemia, leukemia or low platelets ..... Yes No
4. Epilepsy or convulsions? ..... Yes No
5. Asthma or hay fever? ..... Yes No
6. Tuberculosis ..... Yes No
7. Diabetes? How long ..... Yes No
8. Kidney trouble? ..... Yes No
9. Liver trouble or jaundice? ..... Yes No
10. Thyroid trouble or goiter? ..... Yes No
11. Syphilis? ..... Yes No
12. Fainting or dizziness? ..... Yes No
13. Glaucoma? ..... Yes No
14. Arthritis? ..... Yes No
15. HIV AIDS? ..... Yes No
16. Stroke? ..... Yes No
17. Stomach ulcer? ..... Yes No
18. Heart murmur? ..... Yes No
19. Prostate trouble? ..... Yes No
20. Hepatitis? ..... Yes No
21. Eczema or hives? ..... Yes No
22. Psychiatric treatment? ..... Yes No
23. Are you pregnant? ..... Yes No

Are you now taking:

1. Drugs for high blood pressure? ..... Yes No
2. Drugs for sleep? ..... Yes No
3. Cortisone, steroids or ACTH? ..... Yes No
4. Anticoagulants or blood thinner? ..... Yes No
5. Tranquilizers or sedatives? ..... Yes No
6. Antibiotics? ..... Yes No
7. Insulin? ..... Yes No
8. Have you ever taken Fen-Phen? ..... Yes No
9. Others? ..... Yes No
10. List any questions:_____

_____

11. Have you been under the care of a physician for any major illness or injury other than those noted above. If so, list.

_____

I Understand That Payment Is Due At Time Of Service.

I will pay today by: CASH ☐ CHECK ☐ CREDIT CARD ☐

I also acknowledge that I have been given or offered a copy of the offices "Notice of Privacy Practices".

Signature_____**Date**_____

Our office is committed to meeting or exceeding the standards of infection control mandated by the OSHA, the CDC and the ADA.