Pinnacle dental group

Patient Registration

First Name: _____ Last Name: _____

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.: _____

Email: _____ ○ I would like to receive correspondences via e-mail.

How did you hear about our office? _____

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

EMERGENCY CONTACT:

PRIMARY INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec.: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

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

Rem. Benefits: _____.00 Rem. Deduct.: _____.00

SECONDARY INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec.: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

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

Rem. Benefits: _____.00 Rem. Deduct.: _____.00

HEALTH HISTORY

Patient Name: _____ Patient #: _____ Date: _____
Last First M

Please answer each question by checking the appropriate box or circling Yes or No.

1. Are you in good health? ..... Yes No
2. Date of last physical examination: _____
3. Are you now under the care of a physician? ..... Yes No
   If yes, what is the condition being treated? _____
   Doctor's name: _____ Telephone #: _____
4. Have you ever had any serious illness or operation or been hospitalized? ..... Yes No
   Please explain: _____
5. Are you taking any medication? ..... Yes No
   If yes, what? _____ What dosage? _____
6. Are you using any recreational drugs (e.g., marijuana, cocaine) or controlled substances? ..... Yes No
   If yes, what? _____
7. Have you ever been premedicated with antibiotics for your dental treatment? ..... Yes No
8. Are you sensitive or allergic to any drugs or materials? ☐ Penicillin ☐ Tetracycline ☐ Erythromycin
   ☐ Aspirin ☐ Codeine ☐ Latex ☐ Other If Other, please list: _____ ..... Yes No
9. Do you have or have you had any of the following: Please check "Y" for Yes or "N" for No — answer all conditions:

☐Y ☐N AIDS	☐Y ☐N Cortisone Medicine	☐Y ☐N Hemophilia	☐Y ☐N Respiratory Disease
☐Y ☐N Allergies or Hives	☐Y ☐N Diabetes	☐Y ☐N Hepatitis or Jaundice	☐Y ☐N Rheumatic Fever
☐Y ☐N Allergies to Metals	☐Y ☐N Difficulty in Swallowing	☐Y ☐N Herpes	☐Y ☐N Rheumatism
☐Y ☐N Anemia	☐Y ☐N Drug Addiction	☐Y ☐N High Blood Pressure	☐Y ☐N Sickle Cell Disease
☐Y ☐N Angina Pectoris	☐Y ☐N Emphysema	☐Y ☐N HIV Positive	☐Y ☐N Sinus Trouble
☐Y ☐N Arthritis	☐Y ☐N Epilepsy or Seizures	☐Y ☐N Joint Replacement	☐Y ☐N Stomach Ulcers
☐Y ☐N Artificial Heart Valve	☐Y ☐N Excessive Bleeding	☐Y ☐N Kidney Disease	☐Y ☐N Stroke
☐Y ☐N Asthma	☐Y ☐N Fainting Spells or Seizures	☐Y ☐N Liver Disease	☐Y ☐N TMJ
☐Y ☐N Blood Disease	☐Y ☐N Glaucoma	☐Y ☐N Mental Disorder	☐Y ☐N Thyroid Disease
☐Y ☐N Blood Transfusion	☐Y ☐N Hay Fever	☐Y ☐N Mitral Valve Prolapse	☐Y ☐N Tonsillitis
☐Y ☐N Bruise Easily	☐Y ☐N Head Injuries	☐Y ☐N Nervous Disorders	☐Y ☐N Tuberculosis
☐Y ☐N Chemotherapy	☐Y ☐N Heart Ailments or Attack	☐Y ☐N Pain in Jaw Joints	☐Y ☐N Tumors or Growths
☐Y ☐N Cold Sores	☐Y ☐N Heart Failure	☐Y ☐N Psychiatric Treatment	☐Y ☐N Venereal Disease
☐Y ☐N Congenital Heart Lesions	☐Y ☐N Heart Murmur	☐Y ☐N Radiation Treatment	

10. Do you wear a cardiac pacemaker, or have you had heart surgery? If yes, please explain: _____ ..... Yes No
11. Do you smoke, chew, use snuff or any other forms of tobacco? ☐ Cigarettes ☐ Cigars ☐ Chew ☐ Snuff ☐ Other ..... Yes No
    If yes, how much? _____
12. Do you consume alcoholic beverages? If yes, how much? _____ ..... Yes No
13. Have you ever taken the drug "Fen-Phen" or "Redux"? ..... Yes No
14. Are you pregnant? If yes, how many months? _____ ..... N/A Yes No
15. Do you have any problems associated with your menstrual period? ..... N/A Yes No
16. Do you take birth control pills? ..... N/A Yes No
17. Is there anything we should know about your health that is not mentioned above? ..... Yes No
    Please explain: _____

1st I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Date: _____ Signature: _____
(If patient is a minor, include printed name and signature of parent or legal guardian)

2nd ***UPDATE*** *– Since your last visit:*

1. Have you seen a medical doctor? ..... Yes No
2. Have you had a change in any medication? ..... Yes No
3. Have you had a change in any medical condition or had surgery? ..... Yes No

If yes, please explain: _____

Date: _____ Signature: _____

3rd ***UPDATE*** *– Since your last visit:*

1. Have you seen a medical doctor? ..... Yes No
2. Have you had a change in any medication? ..... Yes No
3. Have you had a change in any medical condition or had surgery? ..... Yes No

If yes, please explain: _____

Date: _____ Signature: _____

DO NOT WRITE IN THIS SPACE

	DATE	B.P.	PULSE	REVIEWED BY	DENTIST'S COMMENTS
1st	_____	___/___	_____	_____	_____
2nd	_____	___/___	_____	_____	_____
3rd	_____	___/___	_____	_____	_____