DAN MAZOR D.D.S. PA
NILDA ARCEO DDS. M.S. PA
PERIODONTICS / ORAL IMPLANTOLOGY

PATIENT REGISTRATION AND MEDICAL HISTORY

Patient

Date: | Home Phone:

Last Name: | First Name: | Initial: | Preferred Name:

Street Address: | City: | State: | Zip:

Sex: M ◯ F ◯ | Age: | Birthdate: | ◯ Single ◯ Married ◯ Widowed ◯ Separated ◯ Divorced

Employed By: | Occupation:

Business Address: | Business Phone:

Spouse Name: | Spouse Birthday:

Spouse Employed By: | Occupation:

Business Address: | Business Phone:

Who is Responsible for this account: | Relationship to Patient:

Social Security Number: | Spouse Social Security Number:

Name of Dental Insurance Company: | Group Number:

In case of emergency, Who should be notified? | Phone:

Whom may we thank for referring you?

MEDICAL HISTORY

Physician's Name: | Date of Last Physical:

Have you ever had any of the following? (check boxes that apply):

- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Artificial Heart Valves or Joints
- ☐ Recent Weight Loss
- ☐ Back Problems
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Cancer
- ☐ Psychiatric Care
- ☐ Mitral Valve Prolapse
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ General Allergies
- ☐ Blood Disease
- ☐ Arthritis / Osteoperosis
- ☐ Special Diet
- ☐ Swollen Neck Glands
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ AIDS / HIV
- ☐ Thyroid Disease
- ☐ Stroke
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Hemophilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication? | if so, what?

Have you ever responded adversely to medical or dental treatment?

Are you taking any medication at this time? | if so, what?

Are you under the care of Physician? ◯ Yes ◯ No

For what conditions?

If patient is a child, what is his/her weight?

(Woman) Do you suspect that you are pregnant? ◯ Yes ◯ No | Are you nursing? ◯ Yes ◯ No

Is there anything else we should know about your medical history?

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my Dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: | Digital Signature:

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MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ◯ Yes ◯ No

For what conditions

Are you taking any new medications? | if so, what?

Date | Signature

Date | Doctor's Signature

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