PATIENT REGISTRATION

PATIENT NAME: _____

ADDRESS: _____

CITY: _____ **ZIP CODE:** _____ **DOB:** _____

PHONE: _____ **OTHER PHONE:** _____ **SOCIAL SECURITY:** _____

EMAIL: _____

HAVE YOU HAD SERIOUS ILLINESES OR SURGERIES? IF YES, WHAT? _____

MEDICAL DOCTOR NAME AND PHONE: _____

DATE OF LAST DENTAL EXAM AND X-RAYS _____

CHIEF COMPLAINT: _____ **REFERRED BY:** _____

YES NO CHEST PAIN (ANGINAL)?
YES NO HEPATITIS, LIVER DISEASE, JAUNDICE
YES NO RECENT WEIGTH LOSS, FEVER?
YES NO PERSISTENT COUGH, COUGHIND UP BLOOD?
YES NO BLEEDING PROBLEM,BRUISING EASILY?
YES NO DIFFICULTY SWALLOWING
YES NO DIARRHEA, CONSTIPATION,BLOOD IN STOOLS?
YES NO FREQUENT VOMITING,NAUSEAS
YES NO HEART ATTACK, HEART DEFECTS, MUMUR
YES NO RHEUMATIC FEVER?
YES NO STROKE, HARDERING OF ARTERIES?
YES NO ASTHMA, TB,EMPHYSEMA, LUNG DISEASE
YES NO STOMACH PROBLEMS, ULCERS?
YES NO ALLERGIES TO: DRUGS, FOODS, MEDS, LATEX
YES NO ARTHRITIS, RHEUMATISM?
YES NO VD(SYPHILIS OR GONORRHEA), HIV, HERPES
YES NO KIDNEY, BLADDER DISEASE?
YES NO RADIATIONTREATMENTS, CHEMOTHERAPY
YES NO PROSTHETIC HEART VALVE,PACEMAKER?
YES NO RECREATIONAL DRUG USE?

YES NO DIZZINESS, FAINTING SPELLS
YES NO SHORTNESS OF BREATH?
YES NO RINGING IN EARS?
YES NO BLURRED VISION?
YES NO SEIZURES?
YES NO EXCESSIVE URINATION, THIRST
YES NO DRY MOUTH?
YES NO THYROID,ADRENAL DISEASE
YES NO SKIN DISEASES
YES NO ANEMIA?
YES NO HIGH BLOOD PRESURE
YES NO SWOLLEN ANKLES
YES NO SINUS POBLEMS?
YES NO ALCOHOL USE, TOBACCO, WINE
YES NO EYE DISEASES?
YES NO HEADACHES?
YES NO DIABETES
YES NO BLOOD TRANSFUSIONS?
YES NO ARTIFICIAL JOINT?

YES NO DRUGS,MEDICATIONS, OVER THE COUNTER MEDICINES (INC. ASPIRIN), NATURAL REMEDIES?

_____

_____

IF YOU HAVE ANY ALLERGIES? _____

YES NO DO YOU HAVE OR HAVE YOU HAD DISEASES OR MEDICAL PROBLEMS NOT LISTED? _____

WOMEN ONLY:
YES NO ARE YOU OR COULD YOU BE PREGNANT OR NURSING? _____
YES NO TAKING BIRTH CONTROL PILLS

I RECEIWED AND UNDERSTAND THA HIPPA (PRIVACY ACT) LAST 2 PAGES ON CLIP BOARD
SIGNATURE: _____

I HAVE REVIEWED THE OFFICE FINANCIAL AGREEMENT LAST 2 PAGES ON CLIP BOARD. INITIALS: _____
MISSED APPOINTMENTS OR APPOINTMENT CANCELED WITH OUT 48 HOUR NOTICE WILL BE CHARGE $15 PER HOUR OF APPOINTMENT (MAXIMUM CHARGE $100). REASONABLE EFFORT WILL BE MADE TO CONTACT PATIENT TO CONFIRM APPOINMENTS, STARTING 1 WEEK BEFORE APPOINTMENT.

I AUTHORIZE AND DIRECT PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME, DIRECTLY TO DR STEVEN CRANE, D.M.D. SIGNATURE _____