PATIENT REGISTRATION AND MEDICAL HISTORY

(PLEASE PRINT)

Patient _____
Last Name First name Initial Preferred Name

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced Referred by _____

Sex: ☐ M ☐ F

Employed by _____ Date of Birth _____

Business Address _____ Social Security # _____

_____ e-mail _____

Name of Insurance Company _____ Group Number _____

ADDITIONAL INSURANCE INFORMATION:

Name of Insured _____ Relationship to patient _____

Social Security # _____ Date of Birth _____

Employed by _____ Business Phone _____

Business Address _____

Name of Insurance Company _____ Group Number _____

MEDICAL HISTORY

Physician's Name _____ Phone Number _____

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

☐ Heart Problems	☐ Epilepsy	☐ Sinus Problems
☐ Heart Valve Damage	☐ Neurological Problems	☐ Respiratory Disease
☐ Excessive Bleeding	☐ Stroke	☐ Asthma
☐ High or Low Blood Pressure	☐ Psychiatric Care/Emotional Problems	☐ Cigarette, pipe or cigar smoking
☐ Circulatory Problems	☐ Rheumatic Fever	☐ Unfavorable Dental Experience
☐ Blood Disease	☐ Hepatitis, Jaundice or Liver Disease	☐ Clenching or Grinding
☐ Artificial Joints	☐ Cancer	☐ Dry Mouth
☐ Arthritis	☐ Chemical Dependency	☐ TMJ Treatment
☐ Thyroid Problems	☐ Venereal Disease	☐ Periodontal Treatment
☐ Diabetes	☐ HIV – Immunosuppressive Disorders	Frequency of Brushing _____

Do you have any drug or latex allergies or have you ever had an adverse reaction to medication or anesthetics? ☐ Yes ☐ No

If so, what _____

Taking any medication at this time? ☐ Yes ☐ No If so, what _____

Do you need to Pre-Medicate? ☐ Yes ☐ No If so, with what _____

Under the care of a physician? ☐ Yes ☐ No For what conditions? _____

(Women) Do you suspect that you are pregnant? ☐ 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 Dr. Watson or his staff responsible for errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____