Registration/Medical History

General Information:		
Legal Full Name:		Gender: □ M □ F
Date of Birth:	Social Security #:	
Marital Status: □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated		
Phone Number: Cell:	Home:	
Email Address:		
Street Address:		
City, State, Zip Code:		

Responsible Party:	
Name of Party Responsible for this Account:	Relationship to Patient:
Date of Birth:	Social Security:

Emergency Contact Information:	
Name of Emergency Contact	Phone Number:

Insurance Information:	
Name of Insurance	
Member ID:	Group Number:
Insurance Phone Number:	Employer:

General Medical Information:			
Name of Primary Care Physician:			
Have you ever been hospitalized or had a major operation?			
Have you ever had a serious head or neck injury?			
Please list any medications, pills, or drugs:			
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?			
Are you on a special diet?			
Do you use tobacco?			
Do you use controlled substances?			

WAUKESHA
DENTAL SOLUTIONS

Women: Are You…		
Pregnant?	Nursing?	Taking oral contraceptives?

Do you have Allergies? If yes, please circle:			
Aspirin	Penicillin	Codeine	Acrylic
Latex	Sulfa Drugs	Local Anesthetics	Metal
Other Allergies? If yes, please list:			

Do you have any of the following? If yes, please circle:			
AIDS/HIV	Cortisone Medicine	Hemophilia	Radiation Therapy
Alzheimer's Disease	Diabetes	Hepatitis A	Recent Weight Loss
Anaphylaxis	Drug addiction	Hepatitis B or C	Renal Dialysis
Anemia	Easily Winded	Herpes	Rheumatic Fever
Angina	Emphysema	High Blood Pressure	Rheumatism
Arthritis/Gout	Epilepsy or Seizures	High Cholesterol	Scarlet Fever
Artificial Heart Valve	Excessive Bleeding	Hives or Rash	Shingles
Artificial Joint	Excessive Thirst	Hypoglycemia	Sickle Cell Disease
Asthma	Fainting Spells/Dizziness	Irregular Heartbeat	Sinus Trouble
Blood Disease	Frequent Cough	Kidney Problems	Spina Bifida
Blood Transfusion	Frequent Diarrhea	Leukemia	Stomach/Intestinal Disease
Breathing Problems	Frequent Headaches	Liver Disease	Stroke
Bruise Easily	Genital Herpes	Low Blood Pressure	Swelling of Limbs
Cancer	Glaucoma	Lung Disease	Thyroid Disease
Chemotherapy	Hay Fever	Mitral Valve Prolapse	Tonsilitis
Chest Pains	Heart Attack/Failure	Osteoporosis	Tuberculosis
Cold Sores/Fever Blisters	Heart Murmur	Pain in Jaw Joints	Ulcers
Congenital Heart Disorder	Heart Pacemaker	Parathyroid Disease	Venereal Disease
Convulsions	Heart Trouble/Disease	Psychiatric Care	Yellow Jaundice
Any serious illness not listed above? If yes, please list:			

Do you have any of the following? If yes, please circle:		
Cold Sensitivity	Hot Sensitivity	Sensitivity When Chewing
Sensitivity	Difficulty Chewing	Sore Jaw
Clenching/Grinding	Popping/Clicking of Jaw	Difficulty Opening/Closing
Nervous at Dentist	Bleeding Gums	Food Caught in Teeth
Do you have any dental concerns not listed?		

To the best of my knowledge, the questions on the form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient Signature: _____ Date: _____