sky dental care

ADULT Registration Form

Patient Name: _____ **Date:** _____
Last Name First MI Preferred Name

Home Address: _____

Birth Date: _____ **Sex:** _____ **Marital Status:** _____

Social Security Number: _____ **Drivers License:** _____

Contact #'s Home: _____ **Cell:** _____ **Work:** _____ **ext:** _____

Name of Spouse: _____

Names of immediate family members: _____

Nearest Relative: _____ **Phone:** _____

Preferred Appointment Times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Anytime ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ S

Email Address: _____

Health Information

Previous Dentist: _____ **Date of Last Dental Visit:** _____

Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Mitral Valve Prolapse
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis Type:
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy** Due Date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ _____
- ☐ _____

Please list all medications you are now taking: _____

Have you ever had any complications following dental treatment? ☐ **Yes** ☐ **No**

If yes, please explain: _____

Have you ever been admitted to a hospital or needed emergency care during the past two years? ☐ **Yes** ☐ **No**

If yes, please explain: _____

Are you now under the care of a physician? ☐ **Yes** ☐ **No**

If yes, please explain: _____

Name of Physician: _____

Do you have any health problems that need further clarification? ☐ **Yes** ☐ **No**

If yes, please explain: _____

Whom may we thank for referring you to our practice? _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes to my health, I will inform the doctors at the next appointment without fail.

_____ _____
Signature of patient, parent or guardian Date