

Regency Dental Center Patient Information Form

PLEASE PRINT
COMPLETE FRONT & BACK

PATIENT

Last Name _____ First _____ Middle _____

Address _____ City _____ State _____ Zip _____

Home Phone () _____ Age _____ Date of Birth _____

Sex: Male Female Minor Single Married Widowed

Employer _____ Occupation _____

Employer Address _____ Tel. # _____

Social Security # _____ Drivers License # _____

SPOUSE OR PARENT

Last Name _____ First _____ Middle _____

Employer _____ Occupation _____

Employer Address _____ Tel # _____

PERSON WHO SHOULD BE NOTIFIED IN CASE OF EMERGENCY:

Name _____ Tel # _____ Relationship _____

PERSON RESPONSIBLE FOR ACCOUNT:

Name _____ Tel # _____ Relationship _____

DENTAL INSURANCE Yes No

Insured Person _____ Date of Birth _____ Social Security # _____

Insurance Company Name _____ Group # _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE? _____

MEDICAL HISTORY

1. Are you in good health now?..... Yes No
 2. Are you now under the care of a physician?..... Yes No

If so, what is the condition being treated? _____

Physician's Name _____ Tel # _____

Address _____ City _____ State _____ Zip _____

3. Date of last medical examination _____
 4. Have you ever been hospitalized or had a serious illness?..... Yes No
 5. Have you had excessive bleeding requiring special treatment?..... Yes No
 6. Are you currently taking any medication?..... Yes No

Please list name of medication, purpose & dosage below:

1. _____
 2. _____
 3. _____

7. Are you ALLERGIC or have you ever experienced any reaction to the following?

Local Anesthesia (e.g. Novocain)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Barbiturates/Sedatives/Sleeping Pills	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Penicillin/Other Antibiotics	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Aspirin	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Codeine or other Narcotic	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Sulfa Drugs	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Other Allergies	_____			

8. (Women) Are you pregnant Yes No If so, please give due date _____

Are you nursing? Yes No

Are you taking Birth Control Pills? (Antibiotics make birth control pills ineffective) Yes No