PLEASE PRINT

PATIENT REGISTRATION

Susquehanna Dental WEST

720 Limekiln Rd.
New Cumberland, PA 17070

PATIENT SECTION

NAME *last*	*first*	*middle initial*	NICKNAME	SEX (m) (f)	BIRTHDATE (mo.) (day) (yr.)	MARITAL STATUS (s) (m) (w) (d)

SOCIAL SECURITY NUMBER	HOME ADDRESS *street* *city-state* *zip*	TELEPHONE NUMBER / CELL PHONE /
OCCUPATION *(nature of work, student, housewife, retired)*	BUSINESS ADDRESS *street* *city-state* *zip*	TELEPHONE NUMBER
SPOUSE'S NAME	BUSINESS TELEPHONE NUMBER / EMERGENCY CONTACT	TELEPHONE NUMBER / CELL PHONE /
FAMILY PHYSICIAN	TELEPHONE NUMBER / REFERRED BY	YOUR E-MAIL ADDRESS

INSURANCE OR RESPONSIBLE PARTY

NAME	HOME ADDRESS *street* *city-state* *zip*	TELEPHONE NUMBER / CELL PHONE /
EMPLOYER	ADDRESS *street* *city-state* *zip*	TELEPHONE NUMBER

SOCIAL SECURITY NUMBER	DENTAL INSURANCE YES ☐ NO ☐	INSURANCE COMPANY	CONTRACT NUMBER	GROUP NUMBER
BIRTHDATE / / (mo) (day) (yr.)	SECONDARY DENTAL INSURANCE YES ☐ NO ☐	INSURANCE COMPANY	CONTRACT NUMBER	GROUP NUMBER

PATIENT HEALTH RECORD

Check ✓ Either "Yes" or "No"

(for assistance in completing form please ask)

	YES	NO
1. Are you presently in pain?	☐	☐
2. Are you under any medical treatment now?	☐	☐
3. Are you taking any medication now?	☐	☐
What?_____ For what purpose?_____		
4. Are you allergic to penicillin or have you had an adverse reaction to any drug, food or product (latex, adhesive bandages)?	☐	☐
What?_____		
5. Have you ever been hospitalized?	☐	☐
For what? _____		
6. Have you ever had a serious accident involving head injuries?	☐	☐
7. Have you ever been treated for or been informed you have:		

	YES	NO		YES	NO		YES	NO
Heart Disease	☐	☐	Epilepsy	☐	☐	Venereal Disease	☐	☐
Mitral Valve Prolapse	☐	☐	Psychological or Nervous			Glaucoma	☐	☐
Rheumatic Fever	☐	☐	Disorders	☐	☐	Tumors or Growths	☐	☐
High Blood Pressure	☐	☐	Kidney Trouble	☐	☐	Stroke	☐	☐
Tuberculosis, Emphysema or	☐	☐	Liver Disease, Hepatitis	☐	☐	Asthma	☐	☐
other Lung Diseases	☐	☐	Jaundice	☐	☐	Sinus Problems	☐	☐
Diabetes	☐	☐	Anemia	☐	☐	Glandular Disturbance	☐	☐

8. Have you had a heart valve replacement, stent or joint replacement (hip, knee, etc.)?	☐	☐
9. Has your physician ever recommended medication prior to dental care?	☐	☐
10. Do you often have dizzy spells, fainting, swollen ankles?	☐	☐
11. Does any blood relative in your family have diabetes? Who?	☐	☐
12. Have you ever had severe bleeding after extraction of teeth?	☐	☐
13. Do you smoke, chew tobacco, use snuff or similar substances?	☐	☐
14. (WOMEN) Are you pregnant?	☐	☐
15. Do you have periodic medical checkups:	☐	☐
When was your last physical examination?_____		
16. Do you have periodic dental checkups?	☐	☐
When was your last dental examination?_____		
17. Do you wear contact lenses?	☐	☐
18. Have you any particular concerns about your teeth (bleeding, tender gums, cosmetic, etc.).	☐	☐
19. Are you HIV positive?	☐	☐
20. Are you in good health at this time?	☐	☐

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand this information will be used to determine appropriate dental treatment and I consent to treatment that is necessary and desirable. If there is any change to my medical status, I will inform the dentist. I authorize the release of information necessary to secure payment of benefits. I understand I am financially responsible for fees not paid by insurance. I have received the "Notice of Privacy Practices."

Signature _____ Date _____

Signature of Patient (18 years or older), Parent, Guardian

Signature _____ Date _____