PATIENT REGISTRATION

Patient's Fullname _____ Social Security # _____

Spouse's Name _____ Social Security # _____

Address _____ Phone # _____

City _____ State _____ Zip _____

Parent's Name (If Minor) _____ Address _____

Parent's Employer _____ Work Address or Phone _____

Patient's Employer _____ Work Phone _____

Spouse's Employer _____ Work Phone _____

Friend or Relative living in the Bozeman Area _____ Phone _____

In case of emergency, whom should we notify? _____ Phone _____

Who will pay this account? _____

Do you have Dental Insurance? Yes _____ No _____ If yes, Insurance Company _____

Referred by _____ Policy # _____

MEDICAL HISTORY

Date of Birth _____ Age _____ Date of last Medical Exam _____

Name of Physician _____

Do you have, or have you had any of the following?

Yes	No		Yes	No		Yes	No	
_____	_____	Abnormal Bleeding	_____	_____	Diabetes	_____	_____	Hepatitis
_____	_____	Anemia	_____	_____	Epilepsy	_____	_____	High Blood Pressure
_____	_____	Arthritis	_____	_____	Heart Condition	_____	_____	Mitral Valve Prolapse
_____	_____	Artificial Joints	_____	_____	Heart Murmur	_____	_____	Positive HIV
_____	_____	Asthma	_____	_____	Heart Surgery	_____	_____	Rheumatic Fever

Do You have any other medical conditions? _____

Women: Are you pregnant? Yes _____ No _____ If yes, Date Due _____

Are you taking any Birth Control Pills? Yes _____ No _____

Are you **Allergic** to any of the following?

Yes	No		
_____	_____	Penicillin	
_____	_____	Other Antibiotics	If yes, what antibiotics? _____
_____	_____	Local Anesthetic	
_____	_____	Other Drugs	If yes, what drugs? _____
_____	_____	Foods	If yes, what foods? _____

Are you taking any medications now? Yes _____ No _____ If yes, what drugs? _____

_____

Permission is hereby granted to Dr. Blanchard to perform any necessary dental work for this patient.

Patient's (Parent if minor)
Signature _____ Date _____