

Manhattan Dental

Jon W. Blanchard, DDS

PO Box 190, 118 South 4th Street

Manhattan, MT 59741

406-284-3251

PATIENT REGISTRATION

Patient's Full Name: _____ DOB: ____/____/____

Phone: () _____ - _____

Email Address: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: () _____ - _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Full Name: _____ Maiden Name: _____

If the Patient is a minor (under the age of 18), please provide information for the parent or legal guardian.

Parent/Legal Guardian Name: _____ Phone: () _____ - _____

INSURANCE COMPANY

Insurance Company: _____

Group #: _____

ID # or SSN #: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's Employer: _____ Relationship to Patient: _____

ALLERGIES

Are you allergic to any of the following?

☐ Amoxicillin / Penicillin ☐ Other Antibiotics - If yes, which ones? _____

☐ Local Anesthetic ☐ Other Drugs - If yes, which ones? _____

I authorize Dr. Blanchard to perform any necessary dental work.

Signature: _____

Date: ____/____/____

Manhattan Dental

HEALTH / MEDICAL HISTORY

Name: _____

Allergies (circle one): YES NO

Have you ever been hospitalized or had major operations? _____

Current Medications: _____

Are you pregnant? ☐ Yes ☐ No ☐ N/A If yes, due date: _____

Do you use / drink: ☐ Smoke / Vape ☐ Use Chewing Tobacco ☐ Use Marijuana ☐ Drink Alcohol

How much / How often: _____

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

	YES	NO
A-Fib		
AIDS/HIV		
Alzheimer's Disease		
Anaphylaxis		
Anemia		
Arthritis / Gout		
Artificial Heart Valve		
Artificial Joint		
Asthma		
Blood Disease		
Blood Thinner		
Blood Transfusion		
Breathing Problems		
Bruise Easily		
Cancer		
- If yes, type: _____		
Chemotherapy		
Chest Pains		
Cold Sores / Fever Blisters		
Congenital Heart Disorder		
Cortisone Medicine		
Crohn's / Intestinal Disease / IBS		
Diabetes		
Drug / Alcohol Addiction		
Emphysema		
Epilepsy or Seizure		
Excessive Bleeding		
Excessive Thirst		
Fainting Spells / Dizziness		
Frequent Headaches		
Heart Attack / Failure		
Heart Murmur		
Heart Pacemaker		
Heart Trouble / Disease and More		
Hemophilia		

	YES	NO
Hepatitis A		
Hepatitis B or C		
Herpes		
High Blood Pressure		
High Cholesterol		
Hives or Rash		
Hypoglycemia		
Irregular Heartbeat		
Kidney Problems		
Leukemia		
Liver Disease		
Low Blood Pressure		
Lung Disease		
Mitral Valve Prolapse		
Osteoporosis		
Pain in Jaw Joints		
Parathyroid Disease		
Psychiatric Care / Mental Illness		
Radiation Treatments		
Recent Weight Loss		
Renal Dialysis		
Rheumatic Fever		
Scarlet Fever		
Sexually Transmitted Infection / Disease		
Shingles		
Sickle Cell Disease		
Sinus Trouble		
Spina Bifida		
Stroke		
Swelling of Limbs		
Thyroid Disease		
Tonsillitis		
Tuberculosis		
Tumors or Growths		
Ulcers		