REGISTRATION & HEALTH QUESTIONNAIRE

PLEASE FILL IN YOUR ANSWERS AS THOROUGHLY AS POSSIBLE. ALL INFORMATION WILL BE HELD IN STRICT CONFIDENCE.

❑ Dr. ❑ Mr. ❑ Mrs. ❑ Ms. Date _____

Patient's Name _____ SS# _____ Date of Birth _____

If a child, parent's name _____

Home Address _____

City _____ State _____ Zip _____ Home Phone _____

Place of Employment _____ Work Phone _____ Cell Phone _____

If married, name and occupation of your husband/wife _____

Spouse's birthday _____ Spouse's SS# _____

Emergency Contact _____ Phone (other than home) _____

PRIMARY INSURANCE

Medical ins. name & address _____

Dental ins. name & address _____

Subscriber _____

Subscriber' SS# _____ Date of Birth _____

Subscriber's Employer _____ State _____

SECONDARY INSURANCE

Medical ins. name & address _____

Dental ins. name & address _____

Subscriber _____

Subscriber' SS# _____ Date of Birth _____

Subscriber's Employer _____ State _____

Name, Address and SS# of person responsible for balance of payment _____

If patient is a dependent child, are the natural parents divorced? Yes _____ No _____	If yes, name and address of parent with custody.
Does divorce decree specify which parent is to provide medical coverage? Yes _____ No _____	If yes, which parent is responsible for providing primary coverage? Please furnish his/her name and address if different from parent with custody.

Referred by _____

MEDICAL HISTORY

General health (please check):

❑ Excellent ❑ Good ❑ Fair ❑ Poor

Are you being treated for anything right now? _____

Is your blood pressure: ❑ high ❑ low ❑ normal

Who is your dentist? _____

Who is your physician? _____

If female: Are you pregnant? _____ How long? _____

If yes, what? _____ Surgery? _____

Did you ever have (please check):

❑ joint replacement, type: _____ year: _____

❑ osteoporosis

❑ asthma or lung disorder

❑ anemia

❑ diabetes

❑ hepatitis

❑ bleeding disorder

❑ kidney disease

❑ AIDS, ARC, or HIV-positive

❑ epilepsy

❑ cancer, type: _____

❑ venereal disease

❑ tuberculosis

❑ Diet pills (Redux or Phen-Fen)

❑ liver disease

❑ rheumatic fever

❑ drug or alcohol dependency

❑ thyroid

❑ heart trouble

❑ mitral valve or heart valve problem

❑ disability, explain: _____

❑ other: _____

Are you allergic or sensitive to any medications? _____ **If so, what reaction?** _____

Are you taking any medications now? _____ **If so, what?** _____

I hereby authorize payment of the dental benefits otherwise payable to me directly to Philip D. High, D.D.S.

_____

Signed (patient or parent if minor) Date