DAVID PARIS
DENTISTRY

ParisDentistry.com

(PLEASE PRINT)

# Patient Registration & Medical History

Patient Last Name: ______________________ First Name: ______________________ Initial: ______

Today's Date: ______________ Cell Phone: ______________ Home Phone: ______________

Email Address: ______________________________________________

Street Address: ______________________________________________

City: ______________________ State: ______________ Zip: ______________

I identify as: Male ☐ Female ☐ Non-binary ☐ For purposes of insurance billing, choose one: Male ☐ Female ☐

Age: ________ Birthdate: ______________________ Single ☐ Married/Partnered ☐ Parent ☐

Emergency Contact: ______________________ Relationship to Patient: ______________

Emergency Contact's Phone: ______________________________________________

Name of Dental Insurance Company: ______________________________________________

Dental Insurance Subscriber I.D. #.: ______________________ Group #: ______________

Employed By: ______________________ Occupation: ______________

Who is responsible for this account? ______________________ Relationship to Patient: ______________

Are you now under the care of a physician? ☐ Yes ☐ No

If yes, name of physician: ______________________ Phone: ______________

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: ______________________________________________

*To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.*

Signature: ______________________ Date: ______________
*Patient, Parent or Guardian*

***(continued on next page)***

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## Health Information

Date of last dental visit: ______

Reason for this visit: ______

______

*Have you ever had any of the following? Please check all those that apply:*

- ☐ AIDS
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due Date: ______
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ OTHER: ______

______

Are you taking any medication at this time? ☐ Yes ☐ No

If so, what: ______

Do you have any drug allergies or have you ever had an adverse reaction to any medication? ☐ Yes ☐ No

If so, what: ______

## Referral Information

Whom may we thank for referring you to our practice?

- ☐ Another patient, friend
- ☐ Another patient, relative
- ☐ Yellow Pages
- ☐ Newspaper
- ☐ School
- ☐ Work
- ☐ Dental Office
- ☐ Website

Name of person or office referring you to our practice:

______