

# PATIENT REGISTRATION (MINOR/INSURED DEPENDANT)



Patient Name: \_\_\_\_\_

FIRST NAME M.I. LAST NAME

Address: \_\_\_\_\_ P.O. Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Male  Female  AGE \_\_\_\_\_ Nickname \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Cell No: ( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Minor Living With:

School Attending \_\_\_\_\_  Both Natural Parents

City: \_\_\_\_\_ State: \_\_\_\_\_  Natural Mother  Natural Father

Other \_\_\_\_\_

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Father's Name: \_\_\_\_\_

Address: \_\_\_\_\_ P.O. Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ AGE \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell No: \_\_\_\_\_ E-mail: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Driver's Lic. #: \_\_\_\_\_

Occupation: \_\_\_\_\_ How Long? \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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Mother's Name: \_\_\_\_\_

Address: \_\_\_\_\_ P.O. Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ AGE \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell No: \_\_\_\_\_ E-mail: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Driver's Lic. #: \_\_\_\_\_

Occupation: \_\_\_\_\_ How Long? \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_

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In case of emergency, please notify my nearest relative or acquaintance not living with me.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Relationship \_\_\_\_\_

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Have you been treated by Dr Baker or Cadra in the past? Yes  No

If so, when? \_\_\_\_\_

Describe treatment: \_\_\_\_\_

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Name of my Dentist \_\_\_\_\_

FIRST NAME LAST NAME

I was referred by \_\_\_\_\_

FIRST NAME LAST NAME

**Office Use Only**

Date: \_\_\_\_\_ P: \_\_\_\_\_

Initials \_\_\_\_\_

### Father's Dental Insurance

Name of Policyholder \_\_\_\_\_  
FIRST NAME LAST NAME

Policyholder SS# \_\_\_\_\_ DOB \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Group # \_\_\_\_\_

Insurance Phone(\_\_\_\_) \_\_\_\_\_

Office Use Only	
Eff Date	
Max	Used/Remaining
Ded	Met
Prev	IV
Basic	
Major	
Exam Freq: 1/6 mo	2 in 12 mo
History:	
PX freq:	History:
Dep to age:	Students to age:

### Mother's Dental Insurance

Name of Policyholder \_\_\_\_\_  
FIRST NAME LAST NAME

Policyholder SS# \_\_\_\_\_ DOB \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Group # \_\_\_\_\_

Insurance Phone(\_\_\_\_) \_\_\_\_\_

Office Use Only	
Eff Date	
Max	Used/Remaining
Ded	Met
Prev	IV
Basic	
Major	
Exam Freq: 1/6 mo	2 in 12 mo
History:	
PX freq:	History:
Dep to age:	Students to age:

### Father's Medical Insurance

Name of Policyholder \_\_\_\_\_  
FIRST NAME LAST NAME

Policyholder SS# \_\_\_\_\_ DOB \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Group # \_\_\_\_\_

Insurance Phone(\_\_\_\_) \_\_\_\_\_

### Mother's Medical Insurance

Name of Policyholder \_\_\_\_\_  
FIRST NAME LAST NAME

Policyholder SS# \_\_\_\_\_ DOB \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Group # \_\_\_\_\_

Insurance Phone(\_\_\_\_) \_\_\_\_\_

We thank you for completing this record accurately. Please feel free to ask For assistance if necessary. As with all information contained in your chart, this document is confidential.



V.7.03

Name \_\_\_\_\_

Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_

Male  Female

**HEALTH HISTORY**

1. General Health:  Good  Fair  Poor **YES NO**

2. Are you now or have you been under a physician's care during the past 5 years? \_\_\_\_\_

What for?

3. Are you currently under a doctor's orders? What orders? \_\_\_\_\_

4. Have you ever had a serious illness? What? \_\_\_\_\_

5. Have you had or are you currently having multiple headaches? \_\_\_\_\_

How frequent? \_\_\_\_\_ What causes it? \_\_\_\_\_

6. Have you had or are you currently having neck pain? \_\_\_\_\_

How frequent? \_\_\_\_\_ What causes it? \_\_\_\_\_

7. Have you had previous surgeries? What? \_\_\_\_\_

1 \_\_\_\_\_ ← Age?

2 \_\_\_\_\_

3 \_\_\_\_\_

4 \_\_\_\_\_

5 \_\_\_\_\_

8. Have you ever had a general anesthetic? (put to sleep for surgery) \_\_\_\_\_

9. Have you or anyone in your family had complications with general anesthesia? \_\_\_\_\_

10. Do you have diabetes? \_\_\_\_\_

11. Have you ever taken a prescription diet medication such as Fen-Phen or Redux? \_\_\_\_\_

How recently? \_\_\_\_\_ For how long? \_\_\_\_\_

12. **List all Prescription and NON-Prescription drugs, including Aspirin, Tylenol, Advil, etc.**

	DOSE	Times when Taken

FOR WOMEN ONLY	YES	NO
13. Are you using an oral contraceptive? _____	<input type="checkbox"/>	<input type="checkbox"/>
14. Are you pregnant? Due date? _____	<input type="checkbox"/>	<input type="checkbox"/>
15. Are you trying to become pregnant at this time? _____	<input type="checkbox"/>	<input type="checkbox"/>
16. Are you aware that an antibiotic may interfere with the function of birth control pills? _____	<input type="checkbox"/>	<input type="checkbox"/>

17. Have you had any of the following ?

YES NO IF YES, WHEN WAS THIS?

**HEART DISEASE**

Rheumatic Fever _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Murmur _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Angina _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Attack (Coronary) _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abnormal Electrocardiogram (EKG) _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Surgery _____	<input type="checkbox"/>	<input type="checkbox"/>	What? _____
Pacemaker _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Valve replacement? yes <input type="checkbox"/> no <input type="checkbox"/>			
Chest Pain _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swollen Ankles _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mitral Valve Prolapse _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

**LUNG DISEASE**

Bronchitis _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes:			
Does aspirin make your asthma worse? _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever gone to the emergency room or been admitted to the hospital because of asthma? _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you use an inhaler regularly? _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you use a peak flow meter? _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
(If so, bring this as well as any inhalers you use with you on the day of surgery.)			

Emphysema _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pneumonia _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shortness of Breath _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

**EYE DISEASE**

Glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>	Any medication? _____
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**KIDNEY DISEASE**

_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
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**GASTRIC (STOMACH) ULCER**

_____	<input type="checkbox"/>	<input type="checkbox"/>	When? _____
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**LIVER DISEASE**

_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
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Hepatitis (Yellow Jaundice) \_\_\_\_\_

Cirrhosis _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
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**TUMOR OR CANCER**

_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
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Radiation Therapy \_\_\_\_\_

Chemotherapy _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
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HIV \_\_\_\_\_

HERPES _____	<input type="checkbox"/>	<input type="checkbox"/>	Oral <input type="checkbox"/> Genital <input type="checkbox"/> _____
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**JOINT DISEASE**

HIP JOINT SURGERY _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
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Do you have ANY implanted metal joints? \_\_\_\_\_

Other Joint Surgery _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
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Arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
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**Within** the last **six** months, or **currently**, are you taking:

A. Blood Thinners _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
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B. Cortisone (Steroids) _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
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- |                                                                          | YES                      | NO                       |
|--------------------------------------------------------------------------|--------------------------|--------------------------|
| 18. Do you smoke or use any tobacco products? How much? _____            | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you consume alcohol? How much? _____                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you or have you used illicit drugs? What? _____                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you had seizures? _____                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you had fainting spells? _____                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you wear contact lenses? _____                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do you wish to speak privately with the doctor about anything? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Are You Allergic To:	YES	NO	
Penicillin _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Demerol _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Novacaine _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Codeine _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Aspirin _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Barbiturates _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Latex _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Name of my Physician \_\_\_\_\_  
FIRST NAME LAST NAME

Name of my Dentist \_\_\_\_\_

I was referred by \_\_\_\_\_

I confirm as true the above Health History Information

Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

**OFFICE USE ONLY** This Health History Re-read and Reconfirmed in its entirety and all additions or corrections noted by patient, parent or guardian:

**HEALTH UPDATES**

	Date	Signed
Green	_____	_____
Blue	_____	_____

<b>ASA Classification</b>		
I	II	III

Dr. \_\_\_\_\_ DATE: \_\_\_\_\_

Misc. Information

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