Patient Registration Form

Luck Dental Clinic, INC.

PATIENT INFORMATION (CONFIDENTIAL)

NAME_____PREFFERED NAME_____

ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE _____ MOBILE PHONE_____ WORK PHONE _____

SOC.SEC. # _____BIRTH DATE_____SEX: **MALE** ☐ **FEMALE** ☐

CHECK APPROPRIATE BOX: **MINOR** ☐ **SINGLE** ☐ **MARRIED** ☐

EMPLOYER_____CITY_____STATE_____

IF STUDENT: NAME OF SCHOOL_____ CITY_____STATE_____ FULL TIME ☐ PART TIME ☐

PERSON TO CONTACT IN CASE OF EMERGENCY:_____ PHONE_____

SPOUSE OR PARENT/GUARDIAN NAME_____

SPOUSE'S EMPLOYER_____WORK PHONE_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

DENTAL INSURANCE **YES** ☐ **NO** ☐ **SELF PAY:** **CASH** ☐ **CHECK** ☐ **CREDIT CARD** ☐
(VISA /MASTERCARD/CareCredit©)

PRIMARY DENTAL INSURANCE COMPANY _____

ADDRESS_____CITY_____STATE_____ZIP_____

EMPLOYER_____ INSURANCE ID#_____ GROUP #_____

INSURED BIRTHDATE_____RELATIONSHIP TO YOU: **SELF** ☐ **SPOUSE** ☐ **PARENT** ☐ **OTHER** ☐

SECONDARY INSURANCE/SPOUSES INSURANCE CO._____

ADDRESS_____CITY_____STATE_____ZIP_____

EMPLOYER_____INSURANCE ID#_____ GROUP #_____

INSURED BIRTHDATE_____RELATIONSHIP TO YOU: **SELF** ☐ **SPOUSE** ☐ **PARENT** ☐ **OTHER** ☐

PHYSICIAN'S NAME_____HOSPITAL_____

CITY_____STATE_____DATE OF LAST PHYSICAL/EXAM_____

NEW PATIENTS ONLY:

PREVIOUS DENTIST_____**DATE OF LAST DENTAL EXAM**_____

ADDRESS_____**PHONE (_____)**_____

DO YOU HAVE CURRENT X-RAYS YOU WOULD LIKE TRANSFERED TO OUR OFFICE? **YES / NO** **(PLEASE CIRCLE ONE)**

***OVER PLEASE →**

PATIENT MEDICAL HISTORY PATIENT NAME:

	YES	NO		YES	NO
HEART DISEASE	☐	☐	LIVER DISEASE	☐	☐
CONGENITAL HEART LESIONS	☐	☐	KIDNEY DISEASE	☐	☐
BLOOD PRESSURE **HIGH / LOW** - (**Please circle one**)	☐	☐	HEPATITIS-PLEASE CIRCLE (**A B C**)	☐	☐
ARTIFICIAL HEART VALVE**-DATE**_____	☐	☐	HIV(AIDS)/HERPES VIRUS/OTHER:_____	☐	☐
OPEN HEART SURGERY	☐	☐	BLOOD DISEASE (i.e. prolonged bleeding, anemia)	☐	☐
RHEUMATIC FEVER	☐	☐	ASTHMA OR OTHER RESPIRATORY DISEASE	☐	☐
HEART MURMUR OR MITRAL VALVE PROLAPSE	☐	☐	TUBERCULOSIS	☐	☐
CONGESTIVE HEART DISEASE	☐	☐	SINUS PROBLEMS	☐	☐
PACEMAKER**- DATE**_____	☐	☐	FAINTING	☐	☐
DIABETES	☐	☐	PSYCHIATRIC TREATMENT	☐	☐
STROKE	☐	☐	ULCERS	☐	☐
EMPHYSEMA	☐	☐	DO YOU USE TOBACCO OF ANY KIND	☐	☐
JOINT REPLACEMENT/ARTIFICIAL JOINT-**DATE** _____	☐	☐	CHEMICAL DEPENDENCY	☐	☐
TUMOR HISTORY **-DATE** _____	☐	☐	EPILEPSY/SEIZURES	☐	☐
CHEMOTHERAPY	☐	☐	ALLERGIES –**FOOD/SEASONAL/LATEX**	☐	☐
RADIATION TREATMENT	☐	☐	BIRTH CONTROL PILLS	☐	☐
HEALING COMPLICATIONS	☐	☐	ARE YOU PREGNANT/TRIIMESTER:_____	☐	☐
ARE YOU ALLERGIC TO ANY MEDICATIONS?	☐	☐	OTHER **:**_____	☐	☐

PLEASE LIST:_____

_____

PLEASE LIST ANY DRUGS YOU ARE PRESENTLY TAKING:_____

_____

COMMENTS:_____

_____

_____

SIGNATURE OF PATIENT/GUARDIAN/PARENT **DATE**

INTERNAL USE ONLY:

HEALTH UPDATE:_____DATE_____ INITIALS_____

HEALTH UPDATE:_____DATE_____ INITIALS_____

HEALTH UPDATE:_____DATE_____ INITIALS_____