

REGISTRATION AND HEALTH HISTORY

Date _____

Patients Name _____ Marital Status _____ Age _____

Birthdate _____ Social Security Number _____ Driver's License Number _____

Mailing Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work (Day) Phone _____

Employed By _____ E-Mail Address _____

Name of Spouse _____ Spouse's Social Security Number _____

Spouse's Birthdate _____ Spouse Employed By _____

Who May We Thank for Referring You? _____

Who Will Pay This Account _____ Dental Insurance Company _____

CONFIDENTIAL MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? Yes No

If yes, for what? _____

Physician's Name _____ Phone _____

2. Are you taking any medication, drugs, or pills now? Yes No

During the last two years? Yes No

If yes, please list name and dosage _____

3. Are you aware of having an allergic reaction (or adverse reaction) to any medication or substance? Yes No

If yes, please list: _____

4. Have you been a patient in the hospital during the last five years? Yes No

5. Indicate which of the following you have had, or have at present. Circle "YES" or "NO" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Organ Transplant	Yes	No	Venereal Disease	Yes	No
Chest Pain	Yes	No	Ulcers	Yes	No	AIDS or HIV Positive	Yes	No
Congenital Heart Defects	Yes	No	Diabetes	Yes	No	Excessive Bleeding	Yes	No
Heart Murmur	Yes	No	Thyroid Problems	Yes	No	Cold Sores/Fever Blisters	Yes	No
High Blood Pressure	Yes	No	Glaucoma	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Emphysema	Yes	No	Hemophilia	Yes	No
Mitral Valve Prolapse	Yes	No	Chronic Cough	Yes	No	Sickle Cell Disease	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Bruise Easily	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Liver Disease	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Neurological Disorders	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Epilepsy or Seizures	Yes	No
Swollen Ankles	Yes	No	Sinus Trouble	Yes	No	Fainting or Dizzy Spells	Yes	No
Stroke	Yes	No	Radiation Therapy	Yes	No	Psychiatric Care	Yes	No
Diet (Special/Restricted)	Yes	No	Chemotherapy	Yes	No	Drug Dependency	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Tumors	Yes	No	Alcoholism	Yes	No
Kidney Trouble	Yes	No	Cancer	Yes	No	Smoke Tobacco	Yes	No
Anemia	Yes	No	Hepatitis A or B	Yes	No	Chew Tobacco	Yes	No

WOMEN Are you: Pregnant? Yes, ()Months No Nursing Yes No Using Birth Control Pills Yes No

6. Do you have or have you had any disease, condition, or problem not listed? Yes No

7. Do you use more than two pillows to sleep? Yes No

8. Any other information that should be known about your health: _____

I hereby authorize Dr. Boyes to perform procedures. I also authorize my insurance benefits to be paid directly to Richard S. Boyes D.M.D., P.C. I understand that I am financially responsible for ALL services, to include interest and rebilling charges. I also authorize Dr. Boyes to release any information required. I have either read or received a copy of this offices privacy policy (HIPAA).

Signature _____

Date _____

