Nadimi Dental Care LLC

PATIENT REGISTRATION SHEET

Today's Date:_____

Patient Information

Name (First, Middle, Last):_____

Address :_____ Tel No:_____

Social Security Number:_____ Date of Birth:_____Gender_____

Insurance Information

Primary Insurance: Insurance Subscriber (Full Name)_____DOB_____

Relationship to Subscriber Self/Child/Spouse/Other Employer (If employer plan)_____

Insurance Company_____Group #_____ ID:_____

Secondary Insurance: Insurance Subscriber (Full Name)_____DOB_____

Relationship to Subscriber Self/Child/Spouse/Other Employer (If employer plan)_____

Insurance Company_____Group #_____ ID:_____

Responsible Party_____Date_____

If minor under age 18, parent/guardian must sign. Print Name:_____

PATIENT MEDICAL HISTORY

Medical Doctor Name:_____**Tel No**:_____

Have you ever been hospitalized or had any major operations? ____Yes ____No If yes, Please explain

_____

Do you use Tobacco? ___Yes ___No **Do you use any controlled substances?** ___Yes ___ No

Print Name:_____

Are you taking blood thinners? Such as Coumadin, Warfarin, Xarelto, Pradaxa, Plavix, Heparin or Aspirin?
If yes, which medication are you taking?_____

Are you taking any medications now? ___Yes ___No **If yes, which Medications?**_____

_____

Women: Are you pregnant/Trying to get pregnant? ___Yes___No **Nursing?** ___Yes ___No

Are you Allergic to any of the following? Penicillin Aspirin Codeine Acrylic Metal Latex Other:_____

Do you have any dental problems? ___Yes ___No If yes, which_____

Do you have, or have had, any of the following?

Yes	No		Yes	No	
( )	( )	High Blood Pressure	( )	( )	Asthma
( )	( )	Low Blood Pressure	( )	( )	COPD
( )	( )	Heart Attack	( )	( )	Chest Pain
( )	( )	Heart Disease	( )	( )	Rheumatic Fever
( )	( )	History of Infective Endocarditis	( )	( )	Arthritis
( )	( )	Heart Murmurs	( )	( )	Cancer
( )	( )	Kidney Disease	( )	( )	Sickle Cell disease
( )	( )	Renal Dialysis	( )	( )	Epilepsy/Seizures
( )	( )	Aids/HIV Positive	( )	( )	Respiratory Problems
( )	( )	Hepatitis A	( )	( )	Tuberculosis
( )	( )	Hepatitis B or C	( )	( )	Heart Valve Replacement
( )	( )	Diabetes (Diabetes)	( )	( )	Congenital Heart Disease
( )	( )	Thyroid Problems	( )	( )	Osteoporosis (e.g., taking bisphosphonates
( )	( )	Fainting/Syncope			Medications:_____
( )	( )	Stroke (taking blood thinners)			

( ) ( ) Joint Replacement (Reemplazo de la articulación) If so, how many years ago? _____
( ) ( ) Any Serious Illness not listed above?_____

I Hereby Certify That The Above Information Is Correct. I Authorize The Release Of Any Information Relating To My Dental Claims. I Authorize Assignment of Benefits To The Name Dentist. I Agree to Pay Any Legal Fees Incurred in Collecting This Account.
I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status

Signature of Patient, Parent, or Guardian :_____

Doctor Signature:_____