# Patient Registration & Health History

Michael H. Collins, D.D.S., P.A.

Date: _____

Patient Name: _____

Mailing Address: _____City:_____

State:_____Zip: _____

Gender: M or F Birthdate:_____

Spouse's Name (if applicable)_____

Home Telephone Number: _____Work: _____

Cell: _____

Emergency Contact: _____

Relationship: _____

Contact phone number: _____

Occupation: _____ Employer: _____

If student, name of School/College: _____

Date of last dental visit (if new patient)?_____

Physician/Last Visit/Reason: _____

*If the person responsible for this account is different from the patient or if this patient is a minor, please complete the section below. Otherwise, please skip to the section titled "Insurance Information".*

Minors: Name of responsible party:_____ Relationship to patient: _____

Guardians: _____

Mailing Address: _____City:_____ State:_____Zip: _____

Gender: M or F Birthdate: _____

## Dental Insurance Information (if we don't already have it)

Policy Holder: _____Relationship to patient: _____DOB: _____

Social Security Number: _____ Name of Employer: _____

Insurance Company: _____

Insurance Company Mailing Address: _____

Ins. Telephone Number: _____ID Number: _____ Group Number: _____

## Allergies

| | | |
|---|---|---|
| Local Anesthetic | Barbiturates | Other: _____ |
| Sulfa | Iodine | _____ |
| Metals | Codeine | _____ |
| Penicillin | Latex | |

**Please complete the information on the other side of this document as well**

## Medications

Please list medications you are currently taking, including blood thinners:

_____

_____

***Antibiotic pre-medication may be necessary prior to your appointment. Please circle if you have had the following conditions.**

| | |
|---|---|
| Heart Murmur | Any type of implant |
| Rheumatic Fever | Any type of joint replacement ie: knee/hip |
| Mitral Valve Prolapse | Steroid Treatment |
| Any type of transplant | Congenital Heart Problems |
| Pacemaker | Heart Surgery |

**Please circle any other conditions that you have or have had in the past.**

| | | |
|---|---|---|
| Chest Pain | Eating Disorder | Use of Tobacco Products |
| Heart Failure | Epilepsy | Thyroid Disease |
| Heart Disease or Attack | Seizures | Anemia |
| Angina Pectoris | Persistent Cough | Ulcers |
| Heart Problems | Tuberculosis (TB) | Emphysema |
| Hemophilia | Asthma | Glaucoma |
| Liver Problems | Hepatitis A (Infectious) | Herpes |
| High Blood Pressure | Hepatitis B (Serum) | Hives/Skin rash |
| Blood Transfusion | Hepatitis C or other | Alcoholism |
| Psychiatric treatment | Heart Pacemaker | HIV positive/AIDS |
| Sickle Cell Disease | Stroke | Cancer |
| Sinus Trouble | Drug addiction | Chemotherapy |
| Jaundice | Cold Sores | Diabetes |

Women: Are you pregnant now? Y or N Are you currently breast-feeding? Y or N

Are you taking oral contraceptives? Y or N

I certify that I have read and understand the above information. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to a third party payors and/or health practioners. I authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient or Guardian _____