Lauren Kollar, DDS & Maija Fish, DDS

Patient Registration

Today's Date:__________________ **Home phone:__________________________________**
Patient Name: ____Cell phone:________________________________
Street Address:_______________________________________ Work phone:________________________________
City, State, Zip:_______________________________________ Email address:____________________________
Date of Birth:______________ Marital Status: (single/married/widowed) Sex: (M/F)
Employed By:__________________________________ Occupation:__________________________________
Spouse Name:_____________________________________ Spouse Birthdate:___________________________
Spouse Employed By:________________________________ Spouse Occupation:__________________________
Person responsible for account:________________________ Relationship to patient:______________________
Responsible person's SSN:_____________________________ Patient or spouse's SSN:______________________
Primary Dental Insurance:_______________________ Group #:_______________________ ID #:_____________
Secondary Dental Insurance:_____________________ Group #:_______________________ ID #:___________
Emergency Contact and Phone Number:____
Whom may we thank for referring you?:____

Medications

Please list all Prescriptions and Over-the-Counter medications you are currently taking (we can scan a copy into your digital chart if you carry a med list with you)

Medication	Reason	Dose	Frequency

Please review each medical issue and circle appropriate response:

Pacemaker…Y N	Tuberculosis…Y N
Abnormal/Excessive Bleeding…Y N	Auto Immune Disease…Y N
Anaphylaxis…Y N	Sjogren Disease…Y N
Artificial Heart Valve…Y N	Rheumatoid Arthritis…Y N
Artificial Joint…Y N	Lichen Planus…Y N
Congestive Heart Failure…Y N	Alzheimer's Disease…Y N
Heart Attack…Y N	Osteoporosis/Osteopenia…Y N
Heart Defibrillator…Y N	Bisphosphonate Therapy…Y N
Heart Murmur…Y N	Epilepsy/seizures…Y N
High/Low Blood Pressure…Y N	Fainting Spells/Dizziness…Y N
Irregular Heart Beat…Y N	Thyroid Disease…Y N
Cardiovascular Disease…Y N	Bacterial Endocarditis…Y N
Stroke CVA/MIA…Y N	Depression…Y N
Blood Disease…Y N	Drug/Alcohol Addiction…Y N
Shortness of breath…Y N	Nervous/Anxiety Disorders…Y N
Hemophilia…Y N	Sexually Transmitted Disease (STD)…Y N
Leukemia…Y N	Recent weight loss/gain…Y N
Sickle Cell Disease…Y N	Sleep Apnea…Y N
Cold Sores/Fever Blisters…Y N	Snoring Problems…Y N
Human Papilloma Virus (HPV)…Y N	Tobacco Use…Y N
Hepatitis A, B, C…Y N	Congenital Heart Defect…Y N
Cancer…Y N	Pregnant…Y N
Chemotherapy…Y N	Nursing…Y N
Radiation Treatments…Y N	Sinus Trouble…Y N
Diabetes…Y N	Emphysema…Y N
Dialysis…Y N	Breathing Problems…Y N
Hypoglycemic…Y N	Asthma…Y N
Jaundice…Y N	Liver Disease…Y N
Kidney Problems…Y N	Special Diet…Y N
Blood thinner…Y N	
Hospitalization/surgery history:	
Primary care physician's name:	
Pharmacy:	
Drug allergies:	
Pre-med for heart/joint:	
Have you ever had any serious illness or condition not listed above?	

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

Date:________________ Signature:____