Duxbury Dental Associates

Patient Registration & Medical History Form

(PLEASE PRINT)

PATIENT INFORMATION

Patient's Name:_____ Preferred Name:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Birth Date:____/____/____ Email:_____

Preferred Phone Number #1:_____ Mobile: ☐ Home: ☐ (Please check box)

Preferred Phone Number #2:_____ Mobile: ☐ Home: ☐ (Please check box)

Emergency Contact Name:_____ **Phone #:**_____

MEDICAL HISTORY

Are you?

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Do you have any drug/material allergies?

(For example: penicillin, clindamycin, codeine, latex)_____

Do you have, or have you had, any of the following? (You must circle an answer for each)

AIDS/HIV Positive	YES	NO	Heart Disease	YES	NO
Anaphylaxis History	YES	NO	Heart Murmur	YES	NO
Artificial Joints	YES	NO	Hepatitis/Liver Issues	YES	NO
Asthma	YES	NO	High Cholesterol	YES	NO
Back Issues	YES	NO	Kidney Issues	YES	NO
Blood Disorders	YES	NO	Mental Health Issues	YES	NO
Blood Pressure (HIGH)	YES	NO	Osteoporosis	YES	NO
Blood Pressure (LOW)	YES	NO	Pacemaker	YES	NO
Cancer	YES	NO	Rheumatic/Scarlet Fever	YES	NO
Cardiac Stent	YES	NO	Stroke	YES	NO
Cardiac Valve Placed	YES	NO	Tobacco Use	YES	NO
Chemical Dependency	YES	NO	Thyroid Issues	YES	NO
Diabetes	YES	NO	Ulcer/Colitis	YES	NO
Epilepsy/Fainting	YES	NO	Other:_____	YES	NO

PLEASE LIST ALL CURRENT MEDICATIONS:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you been prescribed an antibiotic to take prior to dental treatment? YES NO If Yes, why? _____

_____

Who prescribed this?_____ Phone #:_____

Signature:_____ **Date:**_____

Printed Name of Patient/Guardian:_____