

Please fill out completely
and sign below

Jeffrey E. Dodge, D.M.D

PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____
 Patient _____ Home Phone (____) _____
 last Name First Name Middle Initial
 Street Address _____ City _____ State _____ Zip _____
 Age _____ Birthdate _____ Social Security# _____ Cell Phone # _____
 School if Full Time Student _____
 Employer _____ Occupation _____
 Business Address _____ Business Phone _____
 Who is responsible for this account? _____ Relation to Patient _____
 Who is insurance holder? _____ DOB _____ Soc Sec# _____
 Address _____
 Employer _____ Work Phone(____) _____
 Dental Insurance Company _____ Member Number _____
 Physician's Name _____ Dentist's Name _____
 Whom may we thank for referring you? _____
 Who do we contact in case of Emergency? _____

MEDICAL HISTORY

In order for us to safely manage your surgery or anesthesia, we need to know about your past medical history. Please complete the questionnaire carefully, even those questions which appear to be unrelated to your problem. As with any portion of your medical record, this document is strictly confidential.

Please review this section carefully circle yes or no for each item. If in doubt, circle the item and this will be reviewed with **you**.

<i>Yes</i>	<i>No</i>	HIGH BLOOD PRESSURE	<i>Yes</i>	<i>No</i>	ASTHMA	<i>Yes</i>	<i>No</i>	DIABETES	<i>Yes</i>	<i>No</i>	IMMUNE DEFICIENCY
<i>Yes</i>	<i>No</i>	RHEUMATIC FEVER	<i>Yes</i>	<i>No</i>	EMPHYSEMA	<i>Yes</i>	<i>No</i>	KIDNEY DISEASE	<i>Yes</i>	<i>No</i>	STROKE
<i>Yes</i>	<i>No</i>	HEART MURMUR	<i>Yes</i>	<i>No</i>	TUBERCULOSIS	<i>Yes</i>	<i>No</i>	ARTHRITIS	<i>Yes</i>	<i>No</i>	SEIZURES
<i>Yes</i>	<i>No</i>	ANGINA (chest pain)	<i>Yes</i>	<i>No</i>	RECENT WEIGHT LOSS	<i>Yes</i>	<i>No</i>	MUSCLE DISEASE	<i>Yes</i>	<i>No</i>	EPILEPSY
<i>Yes</i>	<i>No</i>	HEART ATTACK	<i>Yes</i>	<i>No</i>	CHRONIC VOMITING	<i>Yes</i>	<i>No</i>	BACK PROBLEMS	<i>Yes</i>	<i>No</i>	CANCER
<i>Yes</i>	<i>No</i>	HEART SURGERY	<i>Yes</i>	<i>No</i>	LIVER DISEASE	<i>Yes</i>	<i>No</i>	ULCERS	<i>Yes</i>	<i>No</i>	ARTIFICIAL JOINT/VALVE
<i>Yes</i>	<i>No</i>	SHORTNESS OF BREATH	<i>Yes</i>	<i>No</i>	HEPATITIS	<i>Yes</i>	<i>No</i>	BLEEDING PROBLEMS	<i>Yes</i>	<i>No</i>	CONTACT LENSES
<i>Yes</i>	<i>No</i>	BRONCHITIS	<i>Yes</i>	<i>No</i>	JAUNDICE	<i>Yes</i>	<i>No</i>	ANEMIA	<i>Yes</i>	<i>No</i>	SMOKE

Are you allergic to any drugs or medications?
If so, please list.

Have you ever had any serious disease or illness?
If so, please list.

History of drug or alcohol abuse?

Have you ever been admitted to the hospital (other than emergency room visits)?
If so, please list with dates and reasons.

Have you ever had surgery?
If so, please list with dates.

Do you routinely take medications?
If so, please list with dosage and frequency.

(Women) Are you, or could you be pregnant? _____ Are you taking birth control medication? _____

Is there anything else we should know about your medical history? _____

SIGNED _____

DATE _____