PATIENT REGISTRATION

2003 FORM

Nelson J. Mar, DDS

Date_____

Patient Name _____ Birthdate_____ Age_____
First Middle Last

SS#_____DL#_____ Occupation _____Work # (___)_____

Marital Status: Single___ Married___ Divorced___ Widowed___ Spouses Name: _____ Work # (___)_____

Home Address_____ Zip _____

Home Number (____)_____ Cell Phone (___)_____ Pager #(___)_____

Fax #(___)_____ E- Mail Address _____

Employer Name and Address _____

Person Responsible for Account_____ Relationship_____

Social Security # _____ DL # _____ Home #_____

Home Address (if different)_____ Zip_____

Employer and Address_____

Occupation _____ Work # (____)_____

Referred By _____ Physician _____

Do you have dental insurance? YES_____ NO_____ With Whom? _____

Nearest Relative Not Living With You _____ Relationship_____

Address_____ Zip_____ Phone (_____)_____

Are you currently having dental problems? _____

_____

What are your concerns? ***Circle as many as applicable:*** (Pain Avoidance) (Appearance) (Losing Teeth) (Gum/Periodontal Disease) (Cavities) (Oral Cancer) (Wasting / Exceeding Dental Insurance Limits) (Your General Health) (Routine Checkup) (Cleaning) (Other) _____

Circle yes or no to the following questions:

1.	Are you presently under the care of a physician?	Yes	No
2.	Have you ever had high blood pressure?	Yes	No
3.	Has a physician ever said you have heart trouble?	Yes	No
4.	Do you have Mitral Valve Prolapse?	Yes	No
5.	Have you ever had abnormal bleeding following a cut or extraction?	Yes	No
6.	Have you ever had an anesthetic (either local or general)?	Yes	No
8.	Are you allergic to penicillin, Novocain or any other medication?	Yes	No
	If so, what? _____		
9.	Is the patient allergic to anything other than medicine? (e.g. latex or metals)?	Yes	No
	If so, what? _____		

Do you have or ever had:

1. Rheumatic fever?	Yes	No
2. Rheumatic heart disease?	Yes	No
3. Anemia, leukemia or low platelets?	Yes	No
4. Epilepsy or convulsions?	Yes	No
5. Tuberculosis?	Yes	No
6. Asthma or hay fever?	Yes	No
7. Diabetes? How long?	Yes	No
8. Kidney Trouble?	Yes	No
9. Liver trouble or jaundice?	Yes	No
10. Thyroid trouble or goiter?	Yes	No
11. Syphilis?	Yes	No
12. Fainting or dizziness?	Yes	No
13. Glaucoma?	Yes	No
14. Arthritis?	Yes	No
15. HIV / AIDS?	Yes	No
16. Stroke?	Yes	No
17. Stomach Ulcer?	Yes	No
18. Heart Murmur?	Yes	No
19. Prostate Trouble?	Yes	No
20. Hepatitis?	Yes	No
21. Eczema or Hives?	Yes	No
22. Psychiatric Treatment?	Yes	No
23. Are you pregnant?	Yes	No

Are you now taking:

1. Drugs for high blood pressure?.....	Yes	No
2. Drugs for sleep?.....	Yes	No
3. Cortisone, steroids or ACTH?.....	Yes	No
4. Anticoagulants or blood thinner?.....	Yes	No
5. Tranquilizers or sedatives?.....	Yes	No
6. Antibiotics?	Yes	No
7. Insulin?.....	Yes	No
8. Others?.....	Yes	No
9. Have you ever taken Fen-Phen?.....	Yes	No

List any questions:_____

_____

Have you ever been under the care of a physician for any major illness or injury other than those noted above? If so, please list:

_____

I also acknowledge that I have been given or offered a copy of the offices "Notice of Privacy Practices".

SIGNATURE _____Date _____

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