McManigal Family Dentistry

Patient Name:_____ Birth Date:_____

Are you under a physicians care now?	Y N	Explain:_____
Have you ever been hospitalized or had a major operation?	Y N	Explain:_____
Have you ever had a serious head or neck injury?	Y N	Explain:_____
Are you taking any medications, pills, or drugs?	Y N	Explain:_____
Do you take, or have you taken, Phen-Fen or Redux?	Y N	Explain:_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Y N	
Are you on a special diet?	Y N	
Do you use tobacco?	Y N	
Do you use controlled substances?	Y N	

Women, are you: Pregnant/Trying to get pregnant? Y N Taking oral contraceptives? Y N Nursing? Y N

Are you allergic to any of the following? Aspirin Penicillin Codeine Local anesthetics Acrylic Metal Latex Sulfa drugs Other: If yes, please explain:_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Cortisone Medicine	Hemophilia	Radiation Treatments
Alzheimers Disease	Diabetes	Hepatitis A	Recent Weight Loss
Anaphylaxis	Drug Addiction	Hepatitis B	Renal Dialysis
Anemia	Easily Winded	Herpes	Rheumatic Fever
Angina	Emphysema	High Blood Pressure	Rheumatism
Arthritis/Gout	Epilepsy or Seizures	High Cholesterol	Scarlet Fever
Artificial Heart Valve	Excessive Bleeding	Hives or Rash	Shingles
Artificial Joint	Excessive Thirst	Hypoglycemia	Sickle Cell Disease
Asthma	Fainting Spells/Dizziness	Irregular Heartbeat	Sinus Trouble
Blood Disease	Frequent Cough	Kidney Problems	Spina Bifida
Blood Transfusion	Frequent Diarrhea	Leukemia	Stomach/Intestinal Disease
Breathing Problem	Frequent Headaches	Liver Disease	Stroke
Bruise Easily	Genital Herpes	Low Blood Pressure	Swelling of Limbs
Cancer	Glaucoma	Lung Disease	Thyroid Disease
Chemotherapy	Hay Fever	Mitral Valve Prolapse	Tonsillitis
Chest Pains	Heart Attack/Failure	Osteoporosis	Tuberculosis
Cold Sores/Fever Blisters	Heart Murmur	Pain in Jaw Joints	Tumors or Growths
Congenital Heart Disorder	Heart Pacemaker	Parathyroid Disease	Ulcers
Convulsions	Heart Trouble/Disease	Psychiatric Care	Venereal Disease
			Yellow Jaundice

Have you ever had any serious illness not listed above? Y N

Comments:_____

PATIENT REGISTRATION

Patient is ___Policy Holder
___Responsible Party

Preferred Name:_____

Responsible Party (if someone other than the patient)

First Name:_____ Last Name:_____Middle Initial:____
Address: _____ Address 2:_____
City, State, Zip:_____ Pager:_____
Home Phone:_____ Work Phone:_____ Ext:_____ Cellular:_____
Birth Date:_____ Soc Sec: _____ Drivers Lic:_____
___ Responsible Party is also a Policy Holder for Patient ___ Primary Insurance Policy Holder ___ Secondary Insurance Policy Holder

Patient Information

First Name:_____ Last Name:_____Middle Initial:____
Address:_____ Address 2:_____
City:_____ State/Zip:_____ _____ Pager:_____
Home Phone:_____ Work Phone:_____ Ext:_____ Cellular:_____
Sex: M F Marital Status: Married Single Divorced Separated Widowed
Birth Date:_____ Age:_____ Soc. Sec:_____ Drivers Lic:_____
E-mail:_____ I would like to receive correspondence by emails? Y N

Employment Status: Full Time Part Time Retired
Student Status: Full Time Part Time
Medicaid ID:_____
Employer ID:_____
Carrier ID:_____

Referred By:_____
Previous Dentist:_____
Emergency Contact:_____
Emergency Contact:_____
Emergency Contact #:_____
Spouses Work #:_____
Pref. Pharmacy:_____

Primary Insurance Information

Name of Insured:_____ Relationship to Insured: Self Spouse Child Other
Insured Soc. Sec:_____ Insured Birth Date:_____
Employer:_____ Ins. Company:_____
Address:_____ Address:_____
Address 2:_____ Address 2:_____
City, State, Zip:_____ City, State, Zip:_____
Rem. Benefits:_____ Rem. Deduct:_____

Secondary Insurance Information

Name of Insured:_____ Relationship to Insured: Self Spouse Child Other
Insured Soc. Sec:_____ Insured Birth Date:_____
Employer:_____ Ins. Company:_____
Address:_____ Address:_____
Address 2:_____ Address 2:_____
City, State, Zip:_____ City, State, Zip:_____
Rem. Benefits:_____ Rem. Deduct:_____