

# PATIENT REGISTRATION

Elena C. Puig, DMD, PA, 1600 E. Hillcrest Street, Orlando, FL 32803



Welcome to our office! We are so glad you have chosen us to meet and exceed your dental expectations. Please take the time needed to complete our patient registration, including the insurance information if you have not already given it to one of our staff members.

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_ PREFERRED \_\_\_\_\_

MALE \_\_\_\_\_ FEMALE \_\_\_\_\_ MARRIED \_\_\_\_\_ PARTNERED \_\_\_\_\_ SINGLE \_\_\_\_\_ OTHER \_\_\_\_\_ CHILD \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ SOCIAL SECURITY \_\_\_\_\_ DRIVER'S LICENSE \_\_\_\_\_

### HOME ADDRESS:

NAME OF RESPONSIBLE PARTY \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

STREET \_\_\_\_\_ APARTMENT# \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME TELEPHONE \_\_\_\_\_ WORK TELEPHONE \_\_\_\_\_ EXT. \_\_\_\_\_

PAGER/CELL \_\_\_\_\_ E-MAIL \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ ADDRESS \_\_\_\_\_ HOW LONG THERE? \_\_\_\_\_

OCCUPATION \_\_\_\_\_ WHEN & WHERE ARE THE BEST TIMES TO REACH YOU? \_\_\_\_\_

### INSURANCE INFORMATION: (FOR VERIFICATION ONLY)

SUBSCRIBER \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

INSURANCE CO. NAME \_\_\_\_\_ GROUP # \_\_\_\_\_ PHONE # \_\_\_\_\_

RELATIONSHIP TO SUBSCRIBER:

SELF \_\_\_\_\_ SPOUSE \_\_\_\_\_ CHILD \_\_\_\_\_ OTHER \_\_\_\_\_

EMPLOYER FOR SUBSCRIBER \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_

# HEALTH HISTORY



Circle "Yes" or "No" to indicate if you have had any of the following:

Abnormal bleeding	yes	no	Epilepsy	yes	no	Psychiatric care	yes	no
AIDS	yes	no	Fainting	yes	no	Radiation treatment	yes	no
Anemia	yes	no	Glaucoma	yes	no	Rapid weight loss	yes	no
Arthritis	yes	no	Heart murmur	yes	no	Reactions to drugs	yes	no
Artificial heart valve	yes	no	Heart problems	yes	no	Rheumatic fever	yes	no
Artificial joints	yes	no	Hepatitis	yes	no	Scarlet fever	yes	no
Asthma	yes	no	Herpes	yes	no	Seizures	yes	no
Auto immune disorders	yes	no	High blood pressure	yes	no	Sinus trouble	yes	no
Back problems	yes	no	HIV positive	yes	no	Stroke	yes	no
Blood diseases/transfusions	yes	no	Jaundice	yes	no	Swelling of feet	yes	no
Cancer	yes	no	Jaw pains	yes	no	Systemic diseases	yes	no
Chemical dependency	yes	no	Kidney disease	yes	no	Thyroid disorders	yes	no
Congenital heart lesions	yes	no	Liver disease	yes	no	Tuberculosis	yes	no
Chemotherapy	yes	no	Low blood pressure	yes	no	Tumors	yes	no
Circulatory problems	yes	no	Mitral valve prolapse	yes	no	Ulcers	yes	no
Cortisone treatments	yes	no	Nursing now	yes	no	Venereal disease	yes	no
Cough- persistent	yes	no	Pacemaker	yes	no	Any other	yes	no
Diabetes	yes	no	Parkinsons	yes	no			
Emphysema	yes	no	Pregnant (month)	yes	no			

## MEDICATIONS

List any medications you are on and why

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## ALLERGIES

Are you allergic to any of the following?

____ Aspirin	____ Latex
____ Codeine	____ Penicillin
____ Dental Anesthetics	____ Tetracycline
____ Erythromycin	____ Other
____ Jewelry/Metals	

PHYSICIAN'S NAME \_\_\_\_\_ DATE OF LAST VISIT \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_

PATIENT'S SIGNATURE \_\_\_\_\_

PARENT OR RESPONSIBLE PARTY IF MINOR UNDER 18 \_\_\_\_\_

PARENT OR RESPONSIBLE PARTY SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

DR. REVIEW \_\_\_\_\_