OWINGS MILLS Dental Care

REGISTRATION HISTORY

DATE: _____

PATIENT'S NAME _____ DATE OF BIRTH _____

IF A CHILD, RESPONSIBLE PARTY'S NAME _____ SS# _____

STREET ADDRESS _____ PHONE _____

CITY _____ STATE _____ ZIP _____ CELL PHONE _____

EMPLOYER _____ WORK PHONE _____

EMAIL _____

SINGLE ____ MARRIED ___ DIVORCED ___ WIDOWED ___ SEPARATED ___

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED _____

PURPOSE OF THIS APPOINTMENT _____

WHOM MAY WE THANK FOR REFERRING YOU (INTERNET,RADIO,SUNPAPER,BALTIMORE MAG., TV, OTHER) _____

LAST DENTAL CLEANING _____

MEDICAL HISTORY

Y	N	CONDITIONS
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones/Joints
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Bone Disease/Osteoporosis
☐	☐	Cancer/Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Y	N	CONDITIONS
☐	☐	Glaucoma
☐	☐	Hay Fever
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	HIV/AIDS
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pneumocystitis
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Steroid use

Y	N	CONDITIONS
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tobacco Use (including Vape)
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Yellow Jaundice

Y	N	ALLERGIES
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline
☐	☐	Other: _____

CURRENT MEDICATIONS _____

PREGNANT OR NURSING? _____ SURGICAL HISTORY _____

PRIMARY CARE PROVIDER NAME _____ PRIMARY CARE PROVIDER PHONE _____

SIGNATURE _____ DATE _____