PATIENT REGISTRATION AND MEDICAL HISTORY

Fort Meigs Dental: Drs. Gannon and Kollar, DDS

Date:_____ **Home phone:**_____
Patient Name: _____ **Cell phone:**_____
Street Address:_____ **Work phone:**_____
City, State, Zip:_____ **Email address:**_____
Date of Birth:_____ **Marital Status: (single/married/widowed)** **Sex: (M/F)**
Employed By:_____ **Occupation:**_____
Spouse Name:_____ **Spouse Birthdate:**_____
Spouse Employed By:_____ **Spouse Occupation:**_____
Name of person responsible for account:_____ **Relationship to patient:**_____
Responsible person's SSN:_____ **Patient or spouse's SSN:**_____
Primary Dental Insurance Co:_____ **Primary Ins. Group #:**_____
Secondary Dental Insurance Co:_____ **Secondary Ins. Group #:**_____
Emergency Contact and Phone Number:_____
Whom may we thank for referring you?:_____

MEDICAL HISTORY

Do you need to pre-medicate? Y N
If yes, please explain_____
Have you ever taken bisphosphonates (Fosamax, Boniva, Actonel)? Y N
If yes, please explain_____
Do you have any drug allergies? Y N
If yes, please explain_____
Are you under care of physician now? Y N
If yes, please explain_____
Have you ever been hospitalized or had a major operation? Y N
If yes, please explain_____
Have you ever had a serious head or neck injury? Y N
If yes, please explain_____
Do you use tobacco? Y N
If yes, cigarette pipe/cigar smokeless tobacco
Are you pregnant? Y N
Are you trying to get pregnant? Y N
Are you nursing? Y N
Do you take an oral contraceptive? Y N

Please list all Prescriptions and Over-the-Counter medications you are currently taking (including herbal supplements)

Medication	Reason	Dose	Frequency

Please review each medical issue and circle appropriate response:

Pacemaker…Y N	Tuberculosis…Y N
Excessive Bleeding…Y N	Auto Immune Disease…Y N
Anaphylaxis…Y N	Sjogren Disease…Y N
Artificial Heart Valve…Y N	Rheumatoid Arthritis…Y N
Artificial Joint…Y N	Lichen Planus…Y N
Congestive Heart Failure…Y N	Alzheimer's Disease…Y N
Heart Attack…Y N	Arthritis…Y N
Heart Defibrillator…Y N	Glaucoma…Y N
Heart Murmur…Y N	Osteoporosis…Y N
High/Low Blood Pressure…Y N	Shingles…Y N
Irregular Heart Beat…Y N	Convulsions…Y N
Cardiovascular Disease…Y N	Epilepsy/seizures…Y N
Stroke CVA/MIA…Y N	Fainting Spells/Dizziness…Y N
Anemia…Y N	Hyperthyroid Disease…Y N
Blood Disease…Y N	Hypothyroid Disease…Y N
Blood Transfusion…Y N	Parathyroid Disease…Y N
Bruise Easily…Y N	ADD/ADHD…Y N
Shortness of breath…Y N	Bacterial Endocarditis…Y N
Hemophilia…Y N	Depression…Y N
Leukemia…Y N	Drug/Alcohol Addiction…Y N
Sickle Cell Disease…Y N	Mental Disability…Y N
Cold Sores/Fever Blisters…Y N	Nervous/Anxiety Disorders…Y N
Herpes I, II, Genital…Y N	Psychiatric care…Y N
Human Papilloma Virus (HPV)…Y N	Sexually Transmitted Disease (STD)…Y N
Hepatitis A, B, C…Y N	Contacts…Y N
Cancer…Y N	Recent weight loss…Y N
Chemotherapy…Y N	Sleep Apnea…Y N
Radiation Treatments…Y N	Snoring Problems…Y N
Diabetes…Y N	Stomach/Intestinal Disease…Y N
Dialysis…Y N	Tonsillitis…Y N
Excessive Thirst/Urination…Y N	Ulcers…Y N
Hypoglycemic…Y N	Chest Pain…Y N
Jaundice…Y N	Congenital Heart Defect…Y N
Kidney Problems…Y N	Cortisone Medicine…Y N
Liver Disease…Y N	High Cholesterol…Y N
Asthma…Y N	Sinus Trouble…Y N
Breathing Problems…Y N	Tumors or Growths…Y N
Emphysema…Y N	Swelling of Limbs…Y N
Hay Fever…Y N	Special Diet…Y N
Lung Disease…Y N	
Have you ever had any serious illness or condition not listed above?	

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

Date:_____ Signature:_____