Tulip Dental
FAMILY & COSMETIC DENTISTRY

ID

Chart ID

PATIENT REGISTRATION

First Name _____ Last Name _____

Patient is: ☐ Policy Holder ☐ Responsible Party

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN THE PATIENT)

First Name _____ Last Name _____

Address _____

City _____ State _____ Zip _____

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

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Ext _____ Cellular _____

Birth Date _____ Soc. Sec _____ Drivers Lic _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Email _____ ☐ I would like to receive correspondences via email

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID _____ Pref. Dentist _____

Employer ID _____ Pref. Pharmacy _____

Carrier ID _____ Pref. Hyg. _____

Additional Comments

PRIMARY INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient : ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec _____ Insured Birth Date _____ Employer _____

Address _____

City _____ State _____ Zip _____

Rem. Benefits: _____ .00 Ins. Company _____

Rem. Deduct: _____ .00 _____

City _____ State _____ Zip _____

SECONDARY INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient : ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec _____ Insured Birth Date _____ Employer _____

Address _____

City _____ State _____ Zip _____

Rem. Benefits: _____ .00 Ins. Company _____

Rem. Deduct: _____ .00 _____

City _____ State _____ Zip _____

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MEDICAL HISTORY

* Condition may require medication
N/A - Not answered by patient

Patient Name _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No ☐ N/A _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No ☐ N/A _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No ☐ N/A _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No ☐ N/A _____

Do you take or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No ☐ N/A

Do you use tobacco? ☐ Yes ☐ No ☐ N/A

Are you on a special diet? ☐ Yes ☐ No ☐ N/A

Do you use controlled substances? ☐ Yes ☐ No ☐ N/A

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other _____

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

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

Have you ever had any serious illness not listed above? ☐ Yes ☐ No ☐ N/A

Comments:

_____

_____

_____

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, OF GUARDIAN

DATE