Dr. Rocco V. D'Errico

Patient Registration & Medical History

Date_____Home Phone (_____)_____

Patient _____

Last Name *First Name* *Initial* *Preferred Name*

Street Address_____City_____State _____Zip_____

Sex ❑ M ❑ F Age_____ Birth Date_____/_____/_____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Employed By_____Occupation_____

Business Address_____Business Phone (_____)_____

Spouse Name_____ Spouse Birth Date_____/_____/_____

Spouse Employed By _____Occupation_____

Business Address_____Business Phone (_____)_____

Who is responsible for this account _____Relationship to Patient_____

Social Security # _____/_____/_____ Spouse Social Security # _____/_____/_____

Name of Dental Insurance Company _____

Insurance ID#_____Group #_____

In case of emergency, who should be notified_____Phone (_____)_____

Whom may we thank for referring you?_____

Medical History

Physician's Name_____Date of Late Physical_____/_____/_____

Have you ever had any of the following? *(Check all boxes that apply)*

❑ Heart Problems	❑ Epilepsy	❑ Special Diet
❑ High Blood Pressure	❑ Headache	❑ Swollen Neck Glands
❑ Low Blood Pressure	❑ Hepatitis, Jaundice or Liver Disease	❑ Rheumatic Fever
❑ Circulatory Problems	❑ Cancer	❑ Sinus Problems
❑ Nervous Problems	❑ Psychiatric Care	❑ "AIDS" or other
❑ Radiation Treatment	❑ Chronic Diarrhea	Immunosupressive Disorders
❑ Artificial Heart Valves or Joints	❑ Allergies to Analgesics	❑ Stroke
❑ Recent Weight Loss	❑ Allergies to Medicine or Drugs	❑ Ulcer
❑ Back Problems	❑ General Allergies	❑ Venereal Disease
❑ Diabetes	❑ Blood Disease	❑ Chemical Dependency
❑ Respiratory Disease	❑ Arthritis	❑ Hemophelia

Do you have any allergies or have you ever had an adverse reaction to any medication?_____

If so, explain?_____

Have you ever responded adversely to medical treatment? ❑ Yes ❑ No

If yes, explain_____

Are you taking any medication at this time? If so, what?_____

Are you under the care of a physician? ❑ Yes ❑ No If yes, for what conditions?_____

If a patient is child, what is her/his weight?_____

Women: Do you suspect that you are pregnant? ❑ Yes ❑ No Women: Are you nursing ❑ Yes ❑ No

Is there anything else we should know about your medical history? _____

_____

The above information is accurate and complete to the best of my knowledge and is only for use in any treatment, billing and processing of insurance benfits for which I am entitled. I will not hold any dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Date_____**Signature**_____