Michael V. Razzano D.D.S.
A Family Dental Practice

Patient Registration & Medical History

(Please Print Legibly)

Date:_____

Patient: (last name) _____ (first name) _____ (middle initial) _____ **Preferred name:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

E-Mail: _____ **Cell Phone:** _____ **Home Phone:** _____

Sex: _____ **M** _____ **F** **Age:** _____ **Birth Date:** _____ **Patients SS #** _____

Employer / School: _____ **Occupation:** _____

Status: _____ Married _____ Widowed _____ Single _____ Minor _____ Separated _____ Divorced _____ Other

Whom may we thank for referring you? _____ Insurance ____ Our Website ____ Other Website _____

___ Friend (name) _____ ____ Direct Mail ____ Other _____

Emergency Contact: _____ **Phone:** _____ **Relationship to Patient:** _____

SPOUSE/PARENT RESPONSIBLE PARTY INFORMATION

Name of responsible party for this account: _____ **Relationship to Patient:** _____

Address: (if different than above) _____ **Phone:** _____

Birth Date: _____/_____/_____ **Social Security Number:** _____

Spouse/Parent/Responsible party Employer: _____ **Occupation:** _____

MEDICAL HISTORY

Physicians Name: _____ **Phone:** _____ **Date of Last Physical:** _____/_____/_____

Have you ever had any of the following? (check all that apply)

___ Allergies
___ Arthritis
___ Artificial heart valves, joints, screws
___ Back problems
___ Bleeding abnormally
___ Blood disease
___ Cancer
___ Chemical dependency
___ Chronic diarrhea
___ Circulatory problems
___ Congenial heart disease
___ Diabetes
___ Epilepsy
___ Headaches
___ Heart murmur
___ Heart problems
___ Hemophilia
___ Hepatitis, Jaundice or Liver disease
___ Hernia repair
___ High blood pressure
___ HIV/AIDS
___ Knee/hip replacement
___ Low blood pressure
___ Mitral valve prolapse
___ Nervous problems
___ Organ transplant
___ Pacemaker
___ Psychiatric care
___ Radiation treatment
___ Recent weight loss
___ Respiratory disease
___ Rheumatic fever
___ Sinus problems
___ Special diet
___ Stroke
___ Swollen neck glands
___ Ulcers

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

If yes, describe _____

Have you ever responded adversely to medical or dental treatment? ____ **Yes** ____**No** **If yes, describe** _____

Are you taking any medications at this time? ____ **Yes** ____**No** **If yes, list:** _____

Have you ever taken any of the group drugs collectively referred to as "Fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names ofphentermine), Pondium (fenfluramine) and Redux (dexfenfluramine) ____ **Yes** ____ **No**

Are you under the active care of a physician? ____ **Yes** ____ **No** **If yes, describe:** _____

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

If patient is a child/minor, what is their weight? _____ **pounds**

Women Only: Are you, _____ **Taking birth control?** _____ **Pregnant? Due date** _____ **Nursing?** _____ **Yes** _____ **No**