Patient Registration

Name_____ Date of Birth_____ Age_____ Gender_____

Phone Number_____ Email_____

Emergency Contact_____

Do you have any dental concerns? Explain_____

Have you experienced any of the following? If yes, please CIRCLE

Abnormal bleeding	Heart Failure/Attack	Respiratory Problems
Alcoholism	Heart Murmur	Rheumatic Fever
Angina	Hepatitis C	Rheumatism
Arthritis	High Blood Pressure	Seizures
Artificial Implant/Joint/Valve	HIV+, AIDS, STD's	Shortness of Breath
Asthma	Hives/Skin Rash	Sinus Problems/Hay fever
Cancer	Jaundice	Stent
Cardiac Pacemaker	Kidney Disease	Steroid Treatment
Chest Pains	Leukemia	Stomach Problems
Cold Sores	Liver Disease	Stroke
Diabetes	Low Blood Pressure	Thyroid Problems
Dizziness/Fainting	Mental Health Disorders	Transplant
Emphysema/COPD	Mitral Valve Prolapse	Tuberculosis
Excessive Bleeding	Pacemaker	Tumors
Glaucoma	Pregnancy	Ulcers
Head Injuries	Radiation Treatment	Other_____
Heart Disease	Recent Weigh Loss	

Have you been hospitalized? Why?_____
Have you been told to premedicate prior to dental treatment? Why?_____
Are you under medical treatment now? Why?_____

Are you allergic to:

Latex	Penicillin or other Antibiotics	Local Anesthetics	Sulfa Drugs
Aspirin	Codeine or other Narcotics	Barbituates/Sedatives	Other_____

Are you taking any of the following:

Aspirin	Antidepressants/Tranquilizers	Insulin
Anticoagulants/Blood Thinners	Cortisone/Other Steroids	Nitroglycerin
Antibiotics or Sulfa Drugs	Osteoporosis/Bone Density Meds	Natural Supplements
High Blood Pressure Medicine	Current Medications_____	

Do you Smoke, Vape, use Tobacco, Pot, or other Drugs?_____

Women:
Are you pregnant/plan to become pregnant?_____ Taking hormones/oral contraceptives?_____

By signing below, I acknowledge the importance of a truthful medical history and realize incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate. I authorize His Heart professionals to perform treatment.

Signature_____ Date_____

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