

# PATIENT REGISTRATION FORM

**RICHARD R. PENCE, DDS, PA**

Responsible Party Information

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone:** (\_\_\_\_) \_\_\_\_\_ **Work Phone:** (\_\_\_\_) \_\_\_\_\_

**Social Security #:** \_\_\_\_\_ **Referred By:** \_\_\_\_\_

**Patient Information:** Check if Same as Above \_\_\_\_\_, (Start with Birthday below :)

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone:** (\_\_\_\_) \_\_\_\_\_ **Work Phone:** (\_\_\_\_) \_\_\_\_\_

**Birthday:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Sex:** \_\_\_\_\_

**Marital Status:**    **Single** \_\_\_\_\_    **Married** \_\_\_\_\_    **Divorced** \_\_\_\_\_

**Separated** \_\_\_\_\_    **Widowed** \_\_\_\_\_

**Employment Status:** **Full Time** \_\_\_\_\_    **Part Time** \_\_\_\_\_

**Retired** \_\_\_\_\_    **Not Employed** \_\_\_\_\_

**Student Status:**    **Full Time** \_\_\_\_\_    **Part Time** \_\_\_\_\_

**Not a Student** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Form Completed** \_\_\_\_\_

# Medical History

Physician's name \_\_\_\_\_ Date of last exam \_\_\_\_\_

Birthdate \_\_\_\_\_

**Do you have any of the following? Please indicate with a check mark.**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Any heart problems                 | <input type="checkbox"/> Anemia           | <input type="checkbox"/> Sinus problems   |
| <input type="checkbox"/> High blood pressure                | <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Low blood pressure                 | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Typhoid Fever    |
| <input type="checkbox"/> Circulatory problems               | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Radiation treatments               | <input type="checkbox"/> Herpes           | <input type="checkbox"/> Ulcer            |
| <input type="checkbox"/> Excessive bleeding                 | <input type="checkbox"/> Malignancies     | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Allergies to anesthetics           | <input type="checkbox"/> Mumps            |   |
| <input type="checkbox"/> Allergies to medicines or<br>drugs | <input type="checkbox"/> Psychiatric care |   |
| <input type="checkbox"/> Allergies to _____                 | <input type="checkbox"/> Rheumatic Fever  |   |
|   | <input type="checkbox"/> Scarlet Fever    |   |

Are you pregnant? \_\_\_\_\_ Blood Pressure: S \_\_\_\_\_ / D \_\_\_\_\_ / \_\_\_\_\_

**Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment.**

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Date \_\_\_\_\_ Your Signature \_\_\_\_\_