



SUNRISE DENTAL

REGISTRATION AND MEDICAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

ADDRESS _____

CITY, STATE, ZIP _____

IF CHILD, PARENT'S NAME _____

SS # _____ OCCUPATION _____

PATIENT EMPLOYED BY _____

BUSINESS ADDRESS _____

IN CASE OF EMERGENCY WHOM SHOULD BE NOTIFIED _____

DATE _____

HOME PHONE _____

BUS. PHONE _____

SINGLE _____

MARRIED _____

DIVORCED _____

PHONE _____

DO YOU HAVE ANY INSURANCE THAT MAY COVER ANY PART OF OUR PROFESSIONAL SERVICES? YES _____ NO _____

NAME OF PRIMARY _____	NAME OF SECONDARY _____
ADDRESS _____	ADDRESS _____
POLICY # _____ GROUP # _____	POLICY # _____ GROUP # _____
PATIENTS RELATIONSHIP TO INSURED: SELF _____ SPOUSE _____	PATIENTS RELATIONSHIP TO INSURED: SELF _____ SPOUSE _____
INSURED NAME _____	INSURED NAME _____
INSURED SS# _____ D.O.B. _____	INSURED SS# _____ D.O.B. _____
INSURED EMPLOYER _____	INSURED EMPLOYER _____
EMPLOYER'S ADDRESS _____	EMPLOYER'S ADDRESS _____

PLEASE NOTE: PATIENTS WITH INSURANCE THAT WILL ONLY REIMBURSE THE MEMBER, OR ANY PATIENT WHO RECEIVES INSURANCE CHECKS WILL HAVE 14 DAYS FROM THE DATE THEY RECEIVE AN INSURANCE CHECK TO FORWARD THE CHECK TO OUR OFFICE. IF CHECK IS NOT RECEIVED WITHIN 14 DAYS, THE PATIENT WILL BE BILLED FOR OUR PRIVATE FEES FOR THEIR VISIT. THANK YOU FOR YOUR COOPERATION.

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PHYSICIAN'S NAME _____ PHONE _____

ADDRESS _____

PLEASE CIRCLE

HEART PACEMAKER _____	NO	YES	PROLONGED BLEEDING _____	NO	YES
HEART DISEASE _____	NO	YES	BLOOD TRANSFUSION _____	NO	YES
HEART VALVE REPLACEMENT _____	NO	YES	AIDS _____	NO	YES
ANGINA _____	NO	YES	HEPATITIS _____	NO	YES
RHEUMATIC FEVER _____	NO	YES	DIABETES _____	NO	YES
HEART MURMUR _____	NO	YES	ULCERS _____	NO	YES
PROLAPSED MITRAL VALVE _____	NO	YES	HAY FEVER _____	NO	YES
ABNORMAL BLOOD PRESSURE _____	NO	YES	SINUS PROBLEMS _____	NO	YES
CONGENITAL HEART LESIONS-DEFECTS _____	NO	YES	PERSISTENT COUGH _____	NO	YES
STROKE _____	NO	YES	ASTHMA _____	NO	YES
EPILEPSY/SEIZURE DISORDER _____	NO	YES	EMPHYSEMA _____	NO	YES
JAUNDICE _____	NO	YES	ANEMIA _____	NO	YES
HIV POSITIVE _____	NO	YES	GLAUCOMA _____	NO	YES
GONORRHEA _____	NO	YES	KIDNEY DISEASE OR DIALYSIS _____	NO	YES
SYPHILLIS _____	NO	YES	ANY TRANSPLANTED ORGANS _____	NO	YES
HERPES _____	NO	YES	ANY COMMUNICABLE DISEASES _____	NO	YES
X-RAY OR CHEMOTHERAPY _____	NO	YES	PAIN IN JAW JOINTS _____	NO	YES
DO YOU SMOKE _____	NO	YES	PIN, ROD, OR ANY FOREIGN OBJECT		
DO YOU DRINK ALCOHOLIC BEVERAGES _____	NO	YES	IMPLANTED IN YOUR BODY _____	NO	YES
OFFENSIVE BREATH _____	NO	YES	ANYTHING NOT LISTED _____	NO	YES
DO YOU OR HAVE YOU TAKEN DRUGS _____	NO	YES	IF SO, LIST _____	NO	YES
ARE YOU ALLERGIC TO LATEX _____	NO	YES			
ARE YOU ALLERGIC TO ANY MEDICATION _____	NO	YES	IF SO, LIST _____		
ARE YOU ALLERGIC TO LOCAL DENTAL ANESTHETICS: (NOVOCAINE, XYLOCAINE, CARBOCAINE, ETC) _____	NO	YES			
ARE YOU PRESENTLY TAKING ANY MEDICATION _____	NO	YES	IF SO, LIST _____		
ARE YOU PRESENTLY UNDER THE CARE OF A PHYSICIAN _____	NO	YES	IF SO, LIST REASON _____		
DO YOU NORMALLY TAKE LOCAL ANESTHETIC FOR ROUTINE DENTAL TREATMENT _____	NO	YES			
DO YOUR GUMS BLEED EASILY WHEN BRUSHING _____	NO	YES			
WHEN DID YOU LAST HAVE FULL MOUTH X-RAYS _____					
PURPOSE OF THIS APPOINTMENT _____					

FOR WOMEN ONLY

ARE YOU PREGNANT _____	NO	YES
ARE YOU NURSING _____	NO	YES
ARE YOU TAKING BIRTH CONTROL PILLS _____	NO	YES

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE AND ALL ANSWERS ARE CORRECT. IF I HAVE ANY CHANGE IN MY HEALTH OR MEDICATION, I WILL INFORM YOU IMMEDIATELY.

SIGNATURE OF PATIENT OR GUARDIAN