OFF-ISLAND DENTAL
Family & Cosmetic Dentistry

Patient Registration

Thank you for choosing Off Island Dental to assist you with your dental needs.

Please fill out the information below and don't forget to provide your signature at the end.

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Name ____

Date of Birth ___________ Sex:_______________

If minor, name of legal guardian____________________________________
Home phone ____________________ Mobile phone
_______________________ Work phone____________________

Email
address:____

Mailing address _____________________________ City
____________________State ________ Zip _______________

Employer ___________________________________
Whom may we thank for referring you to our office?
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INSURANCE INFORMATION: ❑Not covered by dental insurance
Your SS# : ______________________ or Member
ID#____
Dental Insurance Co.________________ Group number____________
Claims Address__________________________

Covered by spouse's insurance? ❑yes ❑no Spouse's Name
____

Spouse's dental insurance company _______________________ Group

number ____________________ Spouse's birthday ________________________
SS# or Member ID# ______________________________

MEDICAL HEALTH HISTORY

Do you have, or have you had any of the following? (Please check any that apply)

- ❑ **Are you required to Pre-medicate before any dental treatment ?**

- ❑ Blood Problems (Anemia)
- ❑ Blood transfusion
- ❑ Heart problems
- ❑ Heart murmur, mitral valve prolapse, heart defect ❑ Heart Pacemaker
- ❑ Stroke
- ❑ Bone or joint problems
- ❑ Artificial joint or valves
- ❑ High or low blood pressure (circle one)
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis, jaundice or other liver disease
- ❑ Diabetes TYPE 1 or TYPE 2
- ❑ Epilepsy or Neurological disorders
- ❑ Thyroid problems
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Cancer/Tumor
- ❑ Abnormal bleeding after any surgery (heavy bleeder)
- ❑ Hayfever or sinus trouble ❑ Allergies
- ❑ Asthma

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics
- ❑ Codeine or other narcotics

- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_________________________________

Are you taking any of the following?

❑ Aspirin
❑ Anticoagulants (blood thinners e.g. Coumadin) ❑ Antibiotics or sulfa drugs
❑ High blood pressure medicine
❑ Antidepressants or tranquilizers
❑ Insulin other diabetes drugs
❑ Nitroglycerin
❑ Cortisone or other steroids
❑ Osteoporosis (bone density) medicine
❑ Natural supplements
❑ Other:_______________________________

Women:
❑ Are your pregnant or plant to become pregnant ❑ Taking hormones or contraceptives

Do you smoke,vape or use tobacco?❑yes❑no

Name of your primary medical physician:________________________
Phone number_________________________

Signature of patient (or parent)
______________________________________ Date
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