Registration Form:

(Please Print)

Todays Date: ______________

Name:	Birth Date:
Name of Emergency Contact:	Emergency Contact's Phone #
Preferred Phone # cell / work / home	Place of Employment:
Spouse's Name:	

Physician's Name:		Date of Last Physical:
Have you ever had any of the following? (check all that apply)		
☐ Heart Disease	☐ Chronic Headaches	☐ Sinus Problems
☐ Heart Murmur	☐ Jaw Pain / TMJ Disorder	☐ Reflux disease GERDS
☐ High Blood Pressure	☐ Depression	☐ Ulcers
☐ Bleeding Disorders	☐ Cancer / Tumors	☐ Allergies
☐ Artificial Heart Valves or Pacemaker	☐ Hepatitis, Jaundice, or Liver disease	☐ Substance Abuse
☐ Artificial joints / plates / pins	☐ Chemotherapy	☐ HIV / AIDS / Immune Disorders
☐ Diabetes	☐ Radiation Treatment	☐ Past Surgeries
☐ Lung Disease (Asthma, COPD)	☐ Arthritis	☐ Other
☐ Stroke	☐ Seizure Disorders	☐ Do you use tobacco? If yes, how much per day? ______________
☐ Kidney disease	☐ Rheumatic Fever	

Medications

Please List all current medications below (or provide a list for us to copy).	
1	5
2	6
3	7
4	8

ALLERGIES

Are you allergic to any medications? If so, tell us about your reaction(s).	
1	5
2	6
3	7
4	8

SECTION FOR WOMEN

Are you currently pregnant?	☐ YES	☐ NO	
How many weeks?	☐ 1st Trimester	☐ 2nd Trimester	☐ 3rd Trimester
Are you nursing?	☐ Yes	☐ No	

SECTION FOR KIDS

NAME OF PARENTS OR GUARDIAN:

WHAT IS THE APPROXIMATE WEIGHT OF YOUR CHILD?

DOES YOUR CHILD HAVE A BEHAVIORAL OR DEVELOPMENTAL DISORDER?

☐ YES ☐ NO (IF YES PLEASE EXPLAIN):

NOTE ON CHILDREN'S ROUTINE EXAM: We welcome and suggest the parent(s) accompany their child to the dental office. A child's routine exam at Montevideo Family Dentistry includes cavity detecting x-rays, professional cleaning, exam, and fluoride treatment. Upon signing this form you authorize us to complete the routine checkup procedures listed above. Every child's treatment will vary depending on the condition of his/her oral health condition. In the event your child needs treatment beyond the routine, consent will be obtained from you prior to initiation of treatment. If you have questions, please ask.

PAST DENTAL HISTORY

DATE OF LAST DENTAL VISIT:	NAME OF DENTIST:

HAVE YOU EVER VISITED A DENTAL SPECIALIST IN THE PAST FOR ANY PROCEDURES OR EVALUATIONS? (ORAL SURGEON, PERIODONTIST, ORTHODONTIST, ENDODONTIST.....)

WHO MAY WE THANK FOR YOUR REFERRAL TO OUR OFFICE?

PATIENT: ______________________________ NEWSPAPER / INSURANCE / INTERNET / RADIO

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance benefits for which I am entitled. I will not hold my dentist or any member of his / her staff responsible for any omissions that I may have made in the completion of this form. Please sign below.

X ______________________________ Date: ____________________