Today's Date _____

Full Name _____

How Do You Wish To Be Addressed? _____

Date of Birth _____

Home Address _____

Home Phone Number _____

Employer Phone Number _____

Social Security Number _____

Purpose of this Visit _____

_____

1. Has there been any change in your health in the last year? Yes ____ No ____
2. Are you presently being treated by a physician? Yes ____ No ____

   If yes, why?_____
3. Do you have any of the following conditions:

Hepatitis/Jaundice/Liver	Yes ____	No ____
Rheumatic fever/Heart disease	Yes ____	No ____
Do you have an artificial joint or heart valve implant	Yes ____	No ____
Diabetes	Yes ____	No ____
Heart or circulatory disease	Yes ____	No ____
Heart murmur	Yes ____	No ____
High blood pressure	Yes ____	No ____
Tuberculosis	Yes ____	No ____
Venereal disease/AIDS	Yes ____	No ____
Fainting spells or seizures	Yes ____	No ____
Blood disorders	Yes ____	No ____

4. Are you presently taking any medications? Yes ____ No ____

   Medication Name: For:

   _____

   _____

   _____
5. Do you have instructions from a doctor to pre-medicate before dental treatment? Yes ____ No ____

   If yes, what medication: _____
6. Do you have any allergies? If yes, to what? _____

I hereby give consent to the staff of Fleetwood Dental to perform whatever dental treatment deemed reasonably necessary.

Signature _____
(Parent or guardian, if minor)

Emergency Patient Registration