# PATIENT REGISTRATION AND MEDICAL HISTORY

Date_____ (PLEASE PRINT) Home Phone (____)_____

Patient_____
Last Name First Name Middle Initial Preferred Name

Street Address_____ City_____ State_____ Zip_____

Cell Phone (____)_____ Business Phone (____)_____

Sex ❑ M ❑ F Age_____ Birthdate_____ ❑ Married ❑ Widowed ❑ Single ❑ Minor

Social Security #_____ ❑ Separated ❑ Divorced ❑ Partnered for ____years

Employer_____ Spouse Name_____

Occupation_____ Spouse Birthdate_____

Employer Address_____ Spouse Employed by_____

Employer Phone_____

Whom may we thank for referring you?_____

In case of emergency, who, outside of your home should be notified? Relationship_____

Name _____ Phone (____)_____

## MEDICAL HISTORY

Physician's Name_____ Date of Last Physical_____

Have you ever had any of the following? (check boxes that apply). OR Patient states, none of the below apply _____Initial

❑ Allergies/Sinus Problems
❑ Artificial Heart Valves or Joints, Screws, etc.
❑ Bleeding Abnormally
❑ Blood Disease
❑ Cancer/Radiation Treatment
❑ Chemical Dependency
❑ Circulatory Problems
❑ Diabetes
❑ Epilepsy
❑ Headaches
❑ Heart Murmur
❑ Heart Problems
❑ Hemophilia
❑ Hepatitis, Jaundice or Liver Disease
❑ High Blood Pressure
❑ HIV/AIDS
❑ Low Blood Pressure
❑ Mitral Valve Prolapse
❑ Pacemaker
❑ Psychiatric Care
❑ Respiratory Disease
❑ Rheumatic Fever
❑ Stroke
❑ Swollen Neck Glands
❑ Veneral Disease
❑ Other _____

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia? ❑ Yes ❑ No

If so, what?_____

Do you take any medications for pain on a regular basis, under Dr. prescribed pain management or receive medications as part of a drug rehabilitation program? ❑ Yes ❑ No

Have you ever responded adversely to medical or dental treatment? ❑ Yes ❑ No

Are you taking any medication at this time? ❑ Yes ❑ No If so, what?_____

Are you under the care of a physician? ❑ Yes ❑ No For what conditions?_____

(Women) Do you suspect that you are pregnant? ❑ Yes ❑ No Are you nursing? ❑ Yes ❑ No

Is there anything else we should know about your medical history?_____

_____

### FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians, or personal representatives are responsible for all fees and service rendered for treament of a minor/child. I accept full financial responsibility for all charges for services or items provided to me or the patient. _____Initial

### NOTICE OF PRIVACY

Dr. Carl P. Little has a Notice of Privacy that states how we may use and release your health information. By signing below, you (or your representative) agree that you have been offered the opportunity to review our Notice of Privacy Practices and understand its terms. _____Initial

_____ _____
Signature of Patient or Representative Date

_____ _____
Please print name of Patient or Representative Relationship to Patient