J. A. Llera, D.D.S., P.A.

Registration/ Medical History

First Name _____ Last Name _____
Date of Birth _____-_____-_____ SS# _____- _____-_____
If under 18, name of parent/guardian_____
Married _____ Unmarried _____
Address _____ Apt#_____ City _____ Zip Code_____
Home telephone# :(___) _____-_____ Cellular: (___) _____-_____ Work: (____) ____-_____
Email address: _____
In case of emergency, name and telephone # of person to contact: _____ Phone: (____) ____-_____

Reason for today's visit: _____ Referred by: _____

Do you have dental insurance: no ☐ Yes ☐
Name of Insurance company: _____ Primary insurance subscriber: _____
Primary subscriber's date of birth ___-____-_____
Identification number: _____ Insurance telephone #: (____) _____-_____

Medical History: Please circle "yes" or "no" if you have or have had any of the following:

Anemia Yes / No **Diabetes** Yes / No **Hepatitis** Yes / No **Rheumatic Fever** Yes / No
Cancer Yes / No **Ulcer** Yes / No **Heart Murmur** Yes / No **Pacemaker** Yes / No
High Blood Pressure Yes / No **Low Blood Pressure** Yes / No **Osteoporosis** Yes / No

Are you pregnant: Yes / No **Abnormal Bleeding** Yes / No
Any heart condition: Yes / No **If yes, which one:** _____
Any artificial joint or prosthesis Yes / No **If yes, where:** _____

Allergies: Please circle "yes" or "no" if you have or have had any of the following allergies:

Penicillin Yes / No **Aspirin** Yes / No **Sulfa** Yes / No **Iodine** Yes / No **Latex** Yes / No
Other _____

Are you taking any of the following medications: **Plavix** Yes / No **Coumadin** Yes / No **Fosomax** Yes / No
Any anticoagulants: Yes / No **If yes, which one** _____

Are you taking any medications with or without a prescription? Yes / No
If yes, which ones:
_____

Are you under medical treatment at this time? Yes / No If yes for what reason: _____
Name of physician _____ Telephone (____) _____-_____

Signature _____ Date _____