



## 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:

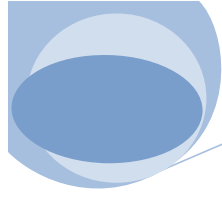
**Penicillin** Yes / No **Aspirin** Yes / No **Sulfa** Yes / No **Iodine** Yes / No **Latex** Yes / No  
**Other** \_\_\_\_\_

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 \_\_\_\_\_



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