FRANK J. TRIANA, D.D.S
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PLEASE PRINT IN INK

ALL INFORMATION WILL REMAIN CONFIDENTIAL

PATIENT REGISTRATION AND MEDICAL HISTORY

1. Your Name Last	First	M.I.	Age	Birthdate	Today's Date

Address	Zip Code	Home Phone

Check One: ☐Child ☐Single ☐Married ☐Divorced ☐Widow

Name of Spouse (or Parent if you are a child)	Patient's Social Security Number	Patient's Work Phone

2. Name of person responsible for payment	Relation to patient
Employed by	How long?
Work Address	Business Phone
Home Address (if different from above)	Home Phone

3. IF YOU HAVE INSURANCE COVERING DENTAL TREATMENT, PLEASE COMPLETE THIS SECTION (incomplete or incorrect answers may result in billing errors)

Name of Insured	Birthdate	Social Security Number

Address	
Insured's Employer	Work Phone
Employer Address	

Insurance Company	Policy Number	Group Number

Do you have any other Dental Insurance? ☐YES ☐NO	If Yes, Give Name of Insurance Company

Name of Insurance Holder	Social Security Number	Policy Number	Group Number

4. Your Physican's Name	Phone Number
Physician's Address	

Date of your last visit to your physician	Date of your last complete medical exam	Reason for your last doctor's visit

5. Do you have allergies to any medicines, foods, drugs? ☐YES ☐NO If yes, to what are you allergic?

6. Have you ever been in a hospital overnight for any reason? ☐YES ☐NO If yes, for what reason?

7. Have you ever had a bad experience in a dental office? ☐YES ☐NO	Date of your last dental checkup

8. Are you taking any medications now? ☐YES ☐NO If yes, please list (include any non-prescription medications)

9. Who referred you to this office?	Name of former dentist

10. List current dental problems:

(continued on reverse)

11. Do you now have or have you had any of the following: (Please check Yes or No).

Yes	No		Yes	No		Yes	No	
☐	☐	Epilepsy	☐	☐	Tuberculosis	☐	☐	Diabetes
☐	☐	Convulsions	☐	☐	High Blood Pressure	☐	☐	Liver Disease
☐	☐	Fainting	☐	☐	Circulatory Problems	☐	☐	Jaundice
☐	☐	Nervous Problems	☐	☐	Stroke	☐	☐	Hepatitis
☐	☐	Psychiatric Care	☐	☐	Anemia	☐	☐	Kidney Disease
☐	☐	Glaucoma	☐	☐	Excessive Bleeding	☐	☐	Tumors
☐	☐	Eye Trouble	☐	☐	Ulcers	☐	☐	Measles
☐	☐	Thyroid Problems	☐	☐	Rheumatic Fever	☐	☐	Radiation Therapy
☐	☐	Asthma	☐	☐	Heart Problems	☐	☐	Arthritis
☐	☐	Venereal Disease (Syphylis, Gonorrhea)	☐	☐	Heart Murmur	☐	☐	Aids
						☐	☐	Pregnant

12. Do you wear contact lenses? ☐YES ☐NO

13. Who may we contact in the event of an emergency?

Name _____ Relation _____

Address _____ Home Phone _____ Business Phone _____

I acknowledge the information in items 1 through 13 is true to the best of my knowledge and that I will report any changes in my health before any treatment is rendered.

_____

Signature Date Reviewed by Date

To the best of my knowledge there has been no change in my health since my last dental examination.

1. Signature _____ Date _____
2. Signature _____ Date _____
3. Signature _____ Date _____
4. Signature _____ Date _____
5. Signature _____ Date _____
6. Signature _____ Date _____
7. Signature _____ Date _____
8. Signature _____ Date _____
9. Signature _____ Date _____
10. Signature _____ Date _____

DOCTOR'S NOTES: