Dr. Lisa A. Goff, D.M.D.

PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

1
DATE
NAME
SPOUSE
ADDRESS
CITY STATE ZIP
HOME PHONE NO.
BIRTHDATE AGE
MARRIED SINGLE DIVORCED WIDOWED
DATE
NAME
ADDRESS
CITY STATE ZIP
HOME PHONE NO.
BIRTHDATE AGE GRADE
SCHOOL
IF YOUR CHILD'S NAME AND ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE ABOVE BOX ALSO.

DENTAL INSURANCE 2
PRIMARY CARRIER
INSURANCE COMPANY
EMPLOYEE
UNION OR LOCAL NO.
GROUP NO.
EMP. BADGE NO.
DATE EMPLOYED
EMP. SOCIAL SECURITY NO.
SECONDARY CARRIER
INSURANCE COMPANY
EMPLOYEE
UNION OR LOCAL NO.
GROUP NO.
EMP. BADGE NO.
DATE EMPLOYED
EMP. SOCIAL SECURITY NO.

ACCOUNT INFORMATION 4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT
NAME
DRIVER'S LICENSE NO.
BANK
BRANCH
ACCOUNT NO.
YOUR:
NAME
OCCUPATION
EMPLOYER
BUSINESS ADDRESS CITY
BUSINESS TELEPHONE EXT.
YOUR SPOUSE:
NAME
OCCUPATION
EMPLOYER
BUSINESS ADDRESS CITY
BUSINESS TELEPHONE EXT.

GETTING TO KNOW YOU 3
IS ANOTHER MEMBER OF YOUR FAMILY, OR RELATIVE A PATIENT AT OUR OFFICE?
THEIR NAME:
REFERRED TO US BY
FORMER ADDRESS
CITY STATE ZIP
PERSON TO CONTACT FOR EMERGENCY
PHONE NUMBER
ADDRESS
CITY STATE ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU
PHONE NUMBER
ADDRESS
CITY STATE ZIP

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HEALTH HISTORY

CIRCLE

1. Are you having pain or discomfort at this time? YES NO
2. Do you feel very nervous about having dental treatment? YES NO
3. Have you ever had a bad experience in the dental office? YES NO
4. Have you been a patient in the hospital during the past two years? YES NO
5. Have you been under the care of a medical doctor during the past two years? YES NO

Physician's Name _____

Address _____ Phone # _____

6. Have you taken any medicine or drugs during the past two years? YES NO
   Are you now taking any medication, drugs or pills? YES NO
   If yes please list _____
7. Are you allergic or have you reacted adversely to any of the following medications? YES NO

Aspirin	Nitrous Oxide	Valium	Local Anesthetic
Darvon	Erthromycin	Scopolamine	(Novocain or Xylocaine)
Codeine	Tetracycline	Penicillin	Sleeping Pills
Demerol	Percodan	Other Antibiotics	(Nembutal/Seconal)

8. Are you aware of being allergic to any other medications or substance? YES NO
   If yes, please list: _____
9. Circle any of the following which you have had or have at present:

Heart Failure	Emphysema	A.I.D.S.
Heart Disease or Attack	Cough	Hepatitis A (infectious)
Angina Pectoris	Tuberculosis (TB)	Hepatitis B (serum)
High Blood Pressure	Asthma	Liver Disease
Heart Murmur	Hay Fever	Yellow Jaundice
Rheumatic Fever	Sinus Trouble	Blood Transfussion
Congenital Heart Lesions	Allergies or Hives	Drug Addiction
Scarlet Fever	Diabetes	Hemophilia
Artificial Heart Valve	Thyroid Disease	Venereal Disease (Syphilis,Gonorrhea)
Heart Pacemaker	X-ray or Cobalt Treatment	Cold Sores
Heart Surgery	Chemotherapy (Cancer, Leukemia)	Fever Blisters
Artificial Joints (Hip, Knee)	Arthritis	Epilepsy or Seizures
Anemia	Rheumatism	Fainting or Dizzy Spells
Stroke	Cortisone Medicine	Nervousness
Kidney Trouble	Glaucoma	Psychiatric Treatment
Ulcers	Pain in Jaw Joints	Sickle Cell Disease
Cosmetic Surgery		Bruise Easily

10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? YES NO
11. Do your ankles swell during the day? YES NO
12. Do you use more than 2 pillows to sleep? YES NO
13. Have you lost or gained more then 10 pounds in the past year? YES NO
14. Do you ever wake up from sleep short of breath? YES NO
15. Are you on a special diet? YES NO
16. Has your medical doctor ever said you have a cancer or tumor? YES NO
17. Do you have any disease, condition, or problem not listed? YES NO

FOR WOMEN ONLY:

Are you pregnant? ☐ Yes ☐ No If yes, what month? _____ Are you taking birth control pills? ☐ Yes ☐ No

ABOVE INFORMATION IS TRUE

Patient Signature _____ Date ___/___/___

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he/she deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 1/2% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____