PATIENT REGISTRATION AND HEALTH HISTORY
RANDAL S. ELLOWAY DDS, INC
Please complete the following confidential information

IF THIS APPOINTMENT IS FOR YOU, PLEASE START HERE:		DATE
NAME	SPOUSE	
ADDRESS		
CITY	STATE	ZIP
HOME PHONE#	CELL PHONE#	EMAIL
WORK PHONE#	BIRTH DATE	AGE
MALE ☐ FEMALE ☐	MARRIED ☐	SINGLE ☐
DIVORCED ☐ WIDOWED ☐	SOCIAL SECURITY #	
IF THIS APPOINTMENT IS FOR YOUR CHILD, PLEASE START HERE:		DATE
NAME		
ADDRESS		
CITY	STATE	ZIP
HOME PHONE#		
BIRTH DATE	AGE	MALE ☐ FEMALE ☐
SCHOOL		GRADE

RESPONSIBLE PARTY FOR THIS ACCOUNT

NAME
DRIVER'S LICENSE#
BANK
BRANCH
YOUR NAME
OCCUPATION
EMPLOYER
BUSINESS ADDRESS
BUSINESS PHONE#
SPOUSE'S NAME
OCCUPATION
EMPLOYER
BUSINESS ADDRESS
BUSINESS PHONE

INSURANCE INFO PLEASE

INSURANCE CO.
EMPLOYEE
DATE OF BIRTH
GROUP #
UNION/LOCAL #
DATE EMPLOYED
EMPLOYEE SS#
SECOND INSURANCE:
INSURANCE CO.
EMPLOYEE
DATE OF BIRTH
GROUP #
UNION/LOCAL #
DATE EMPLOYED
EMPLOYEE SS#

TELL US ABOUT YOU

IS A MEMBER OF YOUR FAMILY A PATIENT HERE?
THEIR NAME
REFERRED BY
YOUR FORMER ADDRESS
CITY
STATE ZIP
PERSON TO CONTACT IN EMERGENCY
PHONE#
ADDRESS
CITY
STATE ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU:
PHONE#
ADDRESS
CITY
STATE ZIP

(OVER)

1. Are you in pain or discomfort at this time? ..... YES NO
2. Have you been a patient in the hospital during the past two years?..... YES NO
3. Have you been under the care of a medical doctor during the past two years?..... YES NO
   Physicians Name _____ Phone#_____
4. Have you taken any medication or drugs during the past two years?..... YES NO
5. Are you now taking any medication, drugs, or pills? ..... YES NO
   If yes, please list: _____
6. Are you a smoker? ..... YES NO
7. Are you, or have you taken any bone density medications, bisphosphonates (i.e. Boniva, Actonel, Fosamax, Zometa, etc.)? ..... YES NO
8. Have you taken Fen-phen?..... YES NO
9. Are you aware of being allergic to, or have you ever reacted adversely to any medications or substance..... YES NO
   If yes, please list: _____
10. Have you ever had an allergic reaction to latex gloves?..... YES NO
11. Indicate which of the following you have at present or have had by circling "yes" or "no".

Heart Failure.....YES NO	Stroke.....YES NO	Hepatitis A (infectious).....YES NO
Heart Disease or Attack.....YES NO	Artificial Joints.....YES NO	Hepatitis B (Serum).....YES NO
Angina Pectoris.....YES NO	Kidney Trouble.....YES NO	Venereal Disease.....YES NO
Congenital Heart Disease.....YES NO	Ulcers.....YES NO	Auto Immune Disease.....YES NO
Heart Murmur.....YES NO	Diabetes.....YES NO	Cold Sores.....YES NO
High Blood Pressure.....YES NO	Thyroid Problems.....YES NO	Fever Blisters.....YES NO
Arteriosclerosis.....YES NO	Glaucoma.....YES NO	Blood Transfusion.....YES NO
Mitral Valve Prolapse.....YES NO	Cosmetic Surgery.....YES NO	Hemophilia.....YES NO
Artificial Heart Valve.....YES NO	Emphysema.....YES NO	Anemia.....YES NO
Heart Pacemaker.....YES NO	Chronic Cough.....YES NO	Sickle Cell Disease.....YES NO
Heart Surgery.....YES NO	Tuberculosis.....YES NO	Bruise Easily.....YES NO
Rheumatic Fever.....YES NO	Asthma.....YES NO	Liver Disease.....YES NO
Arthritis.....YES NO	Hay Fever.....YES NO	Yellow Jaundice.....YES NO
Rheumatism.....YES NO	Allergies or Hives.....YES NO	Epilepsy or Seizures.....YES NO
Pain in Jaw Joints.....YES NO	Sinus Trouble.....YES NO	Fainting or Dizzy Spells.....YES NO
Cortisone Medicine.....YES NO	Radiation Therapy.....YES NO	Nervousness.....YES NO
Drug Addiction.....YES NO	Chemotherapy.....YES NO	Psychiatric Treatment.....YES NO

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

Are you pregnant? YES, what month?____ NO Are you nursing? YES NO Are you taking birth control pills YES NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

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, medications and therapy that may be indicated in connection with:

(name of Patient)_____ and further authorize and consent that Doctor choose and employ such assistance deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for the payment for dental services provided in this office for myself of my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1½ % finance charge (18% annually) will be added to any balance over 60 days. In the event of a 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. I hereby certify that the facts set forth in the above credit application are true and complete to the best of my knowledge. You are hereby authorized to make any investigation of my financial and credit record through any investigation or credit agencies or bureaus of your choice.

Patient_____ Date_____ Witness_____

Parent or Responsible Party_____ Relationship to Patient_____