

Renaissance Dental Center

3803-A Computer Drive, Suite 200, Raleigh, NC 27609

Phone (919) 786.6766

www.northhillsdentists.com

Patient Registration

Patient Information	
Last Name: _____	First Name: _____
Initial: _____	
Preferred Name: _____	
Birth Date: _____	Soc. Sec. # _____
Drivers Lic: _____	
Address: _____	
City: _____	State: _____
Zip: _____	
Home Ph: _____	Cell Ph: _____
Work Ph: _____ ext _____	
Email: _____	
<input type="checkbox"/> I would like to receive correspondence via e-mail.	
<input type="checkbox"/> I would like to receive correspondence via text message.	

Responsible Party (if someone other than patient)	
Last Name: _____	First Name: _____
Initial: _____	
Birth Date: _____	Soc. Sec. # _____
Driver License: _____	
Address: _____	
City: _____	State: _____
Zip: _____	
Home Ph: _____	Cell Ph: _____
Work Ph: _____ ext _____	
Email: _____	
Spouse, Parent or Guardian Name: _____	
Relationship to patient: _____	

Sex:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Marital Status:	<input type="checkbox"/> Married	<input type="checkbox"/> Single	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated	<input type="checkbox"/> Widowed
------	-------------------------------	---------------------------------	-----------------	----------------------------------	---------------------------------	-----------------------------------	------------------------------------	----------------------------------

Primary Insurance Information	
Name of Policy Holder: _____	
Relationship to Insured:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Policy Holder SSC.# or ID#: _____	Policy Holder Birth Date: _____
Employer: _____	Group#: _____
Insurance Company: _____	Insurance Co. Ph#: _____

Employment Status:	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/> Retired	<input type="checkbox"/> Self Employed	<input type="checkbox"/> N/A
Student Status:	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/> N/A		
Name of School: _____					
Referred by: _____					
Emergency Contact Name: _____			Emergency Contact Ph #: _____		
Pharmacy Preferred: _____			Ph# or Location: _____		

Preferred Dentist:	<input type="checkbox"/> Anna Abernethy, DDS
	<input type="checkbox"/> Anita Wells, DDS
	<input type="checkbox"/> Jill Sonner, DDS
	<input type="checkbox"/> N/A

Renaissance Dental Center Medical History

Patient Name: _____

Birth Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

	Yes	No	
Are you under a physician's care now?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please explain: _____
Have you ever had a serious head or neck injury?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please explain: _____
Are you taking any medication, pills, or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please explain: _____
Do you take, or have you taken, Phen-fen or Redux?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you on a special diet?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you use controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>	
Women: Are You: Pregnant /Trying to get pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Taking oral contraceptives? <input type="checkbox"/> Yes <input type="checkbox"/> No Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you allergic to any of the following?	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine <input type="checkbox"/> Acrylic <input type="checkbox"/> Metal <input type="checkbox"/> Latex <input type="checkbox"/> Local Anesthetics
<input type="checkbox"/> Other : If yes, please explain: _____			

Do you have, or have you had, any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Rash	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Limbs	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tonsilitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Parathyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Cold Sores/Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric care	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatments	<input type="checkbox"/>	<input type="checkbox"/>	Yellow jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any serious illness not listed above?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please explain: _____					

Medications / Vitamins / Supplements: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian: _____

Date: _____