JEFFREY T. BAKER DDS PC

EXCELLENCE IN DENTISTRY

Patient Registration & Medical History

Thank you for choosing our office to assist you with your dental needs.

Patient Name _____ Date of Birth _____

Sex _____

If minor, name of legal guardian _____

Home Phone _____ Mobile Phone _____ Work Phone _____

Okay to call: Yes ( ) No ( ) Okay to call: Yes ( ) No ( )

( ) Single ( ) Married ( ) Widowed ( ) Separated ( ) Divorced ( ) Other

Email Address _____

Mailing Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____

Who is responsible for this account? _____ Relationship to patient _____

Whom may we thank for referring you to our office? _____

INSURANCE INFORMATION:

( ) *Not covered by dental insurance*

Your SS# _____ or Member ID# _____ Group Number _____

Dental Insurance Co. _____

Claims Address _____

Covered by another's insurance? Yes ( ) No ( ) If yes, Name of Insured _____

Insured's Dental Insurance Company _____

Claims Address _____

Insured's SS# _____ or Member ID # _____

Group Number _____ Insured's Birthday _____

Name of your primary medical physician _____

Phone number _____

See next page for Medical History.

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(PHONE) 586-992-9222 • (FAX) 586-992-0814 • www.smilesbybaker.com

Medical History

Do you have, or have you had, any of the following? Please check any that apply.

( ) **Are you required to pre-medicate before any dental treatment?**

( ) Abnormal bleeding after any surgery (heavy bleeder)
( ) AIDS or HIV
( ) Arthritis
( ) Artificial joints or heart valves
( ) Asthma
( ) Back problems
( ) Blood disorders
( ) Blood transfusion
( ) Bone or joint problems
( ) Cancer/tumor
( ) Chemical dependency
( ) Chronic diarrhea
( ) Circulatory problems
( ) Diabetes TYPE 1 or TYPE 2
( ) Epilepsy or neurological disorders
( ) General allergies
( ) Hay fever or sinus trouble
( ) Headaches
( ) Heart murmur, mitral valve prolapse, heart defect
( ) Heart pacemaker
( ) Heart problems
( ) Hemophilia
( ) Hepatitis, jaundice or other liver disease
( ) Herpes or cold sores
( ) High or low blood pressure (circle one)
( ) Immunosuppressive disorders
( ) Kidney disease
( ) Nervous issues/Anxiety
( ) Psychiatric care
( ) Radiation treatment/Chemotherapy
( ) Recent weight loss
( ) Respiratory disease
( ) Rheumatic fever
( ) Special diet
( ) Stroke
( ) Swollen neck glands
( ) Thyroid problems
( ) Tuberculosis or other lung problems
( ) Ulcer
( ) Venereal disease
( ) Other: _____

CURRENT

Are you taking any of the following? If checked, history of usage:

( ) Aspirin _____
( ) Antibiotics or sulfa drugs _____
( ) Anticoagulants (blood thinners) _____
( ) Antidepressants or tranquilizers _____
( ) Cortisone or other steroids _____
( ) High blood pressure medicine _____
( ) Insulin or other diabetes drugs _____
( ) Natural supplements _____
( ) Nitroglycerin _____
( ) Osteoporosis (bone density) medicine _____
( ) Other: _____

Women:

( ) Are you pregnant or plan to become pregnant?
( ) Taking hormones or contraceptives **How long?** _____

Are you allergic to, or have you reacted adversely to, any of the following?

( ) Aspirin
( ) Barbiturates/sedatives/sleeping pills
( ) Codeine or other narcotics
( ) Latex
( ) Local anesthetics
( ) Penicillin or other antibiotics
( ) Sulfa drugs
( ) Other: _____

List all medications:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Do you smoke, vape or use tobacco? Yes ( ) No ( )

Is there anything else we should know about your medical history or any recent surgeries?

_____
_____
_____
_____
_____

The above information is accurate and complete to the best of my knowledge and is only for the use in my treatment, billing and/or processing of insurance for benefits for which I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I also understand that I will be charged a finance charge of 1.5 percent if my account is over 90 days old.

Date _____ Patient Signature _____