

Frank L. Higginbottom, D.D.S.

Patient Registration Form

Today's Date

PATIENT'S NAME Mr/Dr/Mrs/Ms _____ BIRTHDATE _____ SEX _____

ADDRESS _____ CITY, STATE _____ ZIP _____

HOME PHONE _____ SOCIAL SECURITY NUMBER _____

CELL PHONE _____ E-MAIL ADDRESS _____

()single ()married ()divorced ()widowed ()employed ()not employed ()full-time student ()part-time student

EMPLOYER _____ WORK PHONE _____ EXT _____

WORK ADDRESS _____ ZIP _____

Patient's relationship to responsible party ()self ()spouse ()child

If patient is NOT the responsible party, please fill out the following additional information:

RESPONSIBLE PARTY NAME Mr/Dr/Mrs/Ms _____

ADDRESS _____ CITY, STATE _____ ZIP _____

SOCIAL SECURITY NUMBER _____ BIRTHDATE _____ HOME PHONE _____

EMPLOYER _____ WORK PHONE _____ EXT _____

WORK ADDRESS _____ CITY, STATE _____ ZIP _____

Dental concerns you wish to discuss at today's appointment _____

Referred by _____ Name of Previous Dentist _____

Date of last dental visit _____ Have you had dental X-Rays taken in the past year? _____

Medical History

Do you have any general health problems? ()yes ()no Explain _____

Physician's Name _____ Phone # _____ Last Physical Exam (date) _____

Are you currently under a physician's care for any condition? ()yes ()no IF YES, PLEASE EXPLAIN _____

What medications are you currently taking? _____

Are you allergic to any medications? ()yes ()no LIST _____

Are you allergic to latex? ()yes ()no Are you allergic to any type of metal? ()yes ()no

Have you ever been told of any need to be pre-medicated with antibiotics for dental procedures? ()yes ()no

Do you currently use tobacco products? ()yes ()no Have you used tobacco products in the past? ()yes ()no
()Cigarettes ()Cigars ()Smokeless Tobacco. Quantity used per day: _____ Years of use: _____

Please complete the remainder of the health history information on the reverse side.

Turn



