Dr. Anshita Agarwal, D.D.S.

PATIENT REGISTRATION & HEALTH HISTORY

PATIENT'S NAME ______________________ DATE OF BIRTH ______________

SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ HOME PHONE ______________

ADDRESS ______________________ CELL PHONE ______________

ADDRESS: CITY/STATE/ZIP ______________________ S.S.# ______________

PERSON RESPONSIBLE FOR PAYMENT ______________________

ARE YOU A COLLEGE STUDENT? ________ FULL TIME ☐ PART TIME ☐ SCHOOL NAME ______________

INSURED EMPLOYED BY & ADDRESS ______________________ BUSINESS PHONE ______________

REFERRED BY ______________________ DATE OF LAST DENTAL EXAM ______________

DENTAL COMPLAINTS

Problem 1. ______________________

2. ______________________

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE WHAT WOULD YOU CHANGE?

____

____

INSURANCE COVERAGE

NAME OF INSURED ______________

EMPLOYER ______________

NAME OF INSURANCE CO. ______________

SS# OF INSURED ______________

UNIQUE # ______________

BIRTHDATE OF INSURED ______________

DEDUCTIBLE ______________

MAXIMUM ______________

CONTRACT YEAR ______________

I II IIII IV

DUAL COVERAGE

NAME OF INSURED ______________

EMPLOYER ______________

NAME OF INSURANCE CO. ______________

SS# OF INSURED ______________

UNIQUE # ______________

BIRTHDATE OF INSURED ______________

DEDUCTIBLE ______________

MAXIMUM ______________

CONTRACT YEAR ______________

I II IIII IV

MEDICAL HISTORY

PHYSICIAN'S NAME ______________ PHONE # ______________ DATE OF LAST PHYSICAL EXAM ______________

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (INDICATE WITH A ✓)

☐ Allergies to drugs ______________

☐ Allergies, sinus problems, or asthma

☐ Any heart aliment or high blood pressure

☐ Latex Allergy

☐ Mitral Valve Prolapse, Rheumatic Fever or heart murmur

☐ Joint or Valve Replacement

☐ Arthritis

☐ Diabetes

☐ Stroke

☐ Tuberculosis

☐ Ulcer or colitis

☐ Hepatitis

☐ TMJ

☐ HIV Positive

☐ Psychiatric care/neurological problems

☐ Excessive bleeding from cut or extraction

☐ Chemotherapy or radiation treatment

☐ Are you pregnant? (What month?) ________

List any current medications you are taking: ______________________

____

____

THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

HIPPA ______________ SIGNATURE ______________________ DATE ______________

PARENT OR GUARDIAN IF PATIENT IS A MINOR