Murthy Dental Clinic
REGISTRATION FORM

Today's date:

PATIENT INFORMATION

Name *(Last, First, M.I.):*	Age:	DOB:
Marital status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed	Sex: ☐M ☐F	
Street address:	Home phone no.: ( )	SSN:
City:	State:	ZIP:

Present Position:	Employer:	How long:	Business Phone no.:
			( )

Purpose of this appointment:

Other family members seen here:

Name of the person to thank for referral:

SPOUSAL/PARENTAL INFORMATION

☐Father ☐ Mother ☐ Husband ☐ Wife	☐ Father ☐ Mother ☐ Husband ☐ Wife
Name *(Last, First, M.I.):*	Name *(Last, First, M.I.):*
Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed	Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed
Employer:	Employer:
Employer Address:	Employer Address:
City: State: ZIP:	City: State: ZIP:
Employer Phone no.:	Employer Phone no.:
Home Address:	Home Address:
City: State: ZIP:	City: State: ZIP:
Home phone no.:	Home phone no.:

INSURANCE INFORMATION

Person responsible for bill:	DOB:	Address (if different):	Home phone no.: ( )

Present Position:	Employer:	Employer address:	Employer phone no.:
			( )

Is this patient covered by insurance?	☐Yes ☐No	Please indicate primary insurance:	

Subscriber's name:	Subscriber's SSN:	DOB:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐Self	☐Spouse	☐Child	☐Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐Self	☐Spouse	☐Child	☐Other

Is policy connected with your union?	Name of Union:	Local no.:	Group no.:
☐Yes ☐No			

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

HEALTH HISTORY QUESTIONNAIRE

Today's date:		
Name *(Last, First, M.I.):*	Age:	DOB:
Marital status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed	Sex: ☐M ☐F	
Previous or referring doctor:	Date of last health exam:	

Date of last health exam:

For what reason(s)?

Have you been hospitalized in last 5 years? ☐Yes ☐No

SURGERIES OR OTHER HOSPITALIZATIONS

Year	Reason

Do you have or have you ever had:

• Anemia	☐Yes ☐No	• Diabetes	☐Yes ☐No	• Epilepsy	☐Yes ☐No
• Hepatitis	☐Yes ☐No	• Rheumatic Fever	☐Yes ☐No	• Heart Murmur	☐Yes ☐No
• Abnormal Heart Condition	☐Yes ☐No	• Abnormal Heart Condition	☐Yes ☐No	• Abnormal Bleeding from cut	☐Yes ☐No

Women: Are you pregnant? ☐Yes ☐No

Are you allergic to:

- Penicillin ☐Yes ☐No
- Local Anesthetic ☐Yes ☐No

Are you allergic to any drugs? ☐Yes ☐No

ALLERGIES TO MEDICATIONS OR DRUGS

Name the Drug	Reaction You Had

Are you taking any medication? ☐Yes ☐No

LIST MEDICATION YOU ARE TAKING

Name the Drug	Reason for medication

Are there any physical conditions? If any, list them ☐Yes ☐No

Name of your physician:	Address:	Phone no.:

May we request your health record, if necessary ☐Yes ☐No

To whom should we address request:

This information was given by: