ADULT | PATIENT REGISTRATION

PATIENT INFORMATION:

Today's Date: _____

Name: _____ Date of Birth: _____ Age: _____

Nickname: _____ Sex: _____ Height: _____ Weight: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

RESPONSIBLE PARTY:

Name of Person/Relationship: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

MEDICAL HISTORY:

Have you ever had any of the following medical problems?

- ☐ Y ☐ N Allergy to Latex
- ☐ Y ☐ N Allergies to Medications (Please list below)
- ☐ Y ☐ N Asthma/Lung Problems
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N High Cholesterol
- ☐ Y ☐ N Heart Murmurs/Defects
- ☐ Y ☐ N Heart Surgery
- ☐ Y ☐ N Other Surgery _____
- ☐ Y ☐ N Seizure Disorder (Epilepsy)
- ☐ Y ☐ N Autism
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Down Syndrome
- ☐ Y ☐ N Other Syndromes _____
- ☐ Y ☐ N Possibly PREGNANT (Women >10 years old)
- ☐ Y ☐ N Cerebral Palsy
- ☐ Y ☐ N Handicaps/Disabilities
- ☐ Y ☐ N Hemophilia
- ☐ Y ☐ N Parkinson's Disease
- ☐ Y ☐ N Alzheimer's Disease
- ☐ Y ☐ N Tuberculosis
- ☐ Y ☐ N Mastocytosis
- ☐ Y ☐ N Tracheal Malacia
- ☐ Y ☐ N Cancer
- ☐ Y ☐ N Muscular Dystrophy
- ☐ Y ☐ N Sickle Cell Anemia
- ☐ Y ☐ N Malignant Hyperthermia (Patient or Familial History)

Please discuss any medical problems that you have/had: _____

_____

Are you currently under the care of a physician? ☐ Yes ☐ No Date of Last Visit: _____

Physician Name: _____ Phone Number: _____

Are you followed by a SPECIALIST? ☐ Yes ☐ No *Please indicate ALL that apply*: ☐ Cardiologist ☐ Endocrinologist

☐ Geneticist ☐ Hematologist ☐ Neurologist ☐ Oncologist ☐ Pulmonologist ☐ Other _____

Please list ALL current medications: _____

Please list ALL allergies (medicine, food, latex, etc.): _____

The information on this questionnaire is accurate to the best of my knowledge. I understand that the information will be held in the **strictest** of confidence and it is my responsibility to inform the doctors of Arizona Dental Anesthesia of any changes in the medical status of this patient at the earliest possible time.

Signature of Parent or Legal Guardian: _____ Date: _____

Reviewed by: _____ Date: _____

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