DRENNAN AND PETTA, P.A.
Patient Registration

Please answer all questions completely. Please print. Date__________________

PATIENT INFORMATION

Name:___________________________ Address:______________________________________

City:___________________________ State:_____________ Zip code:____________________

Home phone:________________ Birth date:______________________ Sex:______________

☐Minor ☐Single ☐Married Occupation:____________________________________

Business phone:______________________ Employed by:______________________________

Social Security #:____________________ Driver's License #:__________________________

Spouse's Name (Parent if minor):___________________ Home phone:____________________

Spouse's Occupation:____________________ Spouse's Employer:______________________

Business phone:____________________

Whom may we thank for referring you to us?_______________________________________

DENTAL INSURANCE INFORMATION

Employee Name:_________________________ Relationship to patient___________________

Birth date____________________ Social Security #:__________________

Work phone:_________________________ Name of employer__________________________

Insurance company_______________________________ Group #:_____________________

Insurance company address____

Do you have additional dental insurance? ☐Yes ☐No

HEALTH INFORMATION

Physician: _______________________________________ Office #:______________________

Question	Yes	No
Have you had any joints replaced or heart valve surgery?	☐Yes	☐No
Do you have a heart murmer?	☐Yes	☐No
Do you have heart trouble?	☐Yes	☐No
Have you had rheumatic fever?	☐Yes	☐No
Are you diabetic?	☐Yes	☐No
Have you ever had infectious hepatitis?	☐Yes	☐No
Do you have any other infectious disease such as: HIV, AIDS, or TB?	☐Yes	☐No
Do you have high blood pressure?	☐Yes	☐No
Do you have respiratory disease?	☐Yes	☐No
Have you ever had blood disease?	☐Yes	☐No

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Have you ever had kidney disease?	☐Yes	☐No
Have you ever had trouble with bleeding or healing after a surgery?	☐Yes	☐No
Do you have any allergies?	☐Yes	☐No

Please list any allergies:____

Please list any medications you are taking:_______________________________________

Is there other information about your hearth I should know?________________________

____

Emergency Contact:____

<u>THANK YOU!</u>