Robert Olan, D.D.S., P.C.
Patient Registration / Medical History

Social Security #___ ___ ___-___ ___-___ ___ ___ ___ Home Phone # ( ) _____
Cell Phone # ( ) _____

Patient _____
Last First

Address _____
Sex: M F Age_____ Birth date_____ Single Married Separated Divorced
Employer_____ Occupation_____
Business Address_____ Work Phone ( ) _____
Family Dentist _____ Phone # ( ) _____
Address _____
Family Physician_____ Phone # _____
How did you hear about our office?_____
Name of Dental Insurance _____
Secondary Insurance Carrier _____

Medical History

Are you in good health? Yes No
Have you ever had any of the following? (Circle all that apply)

AIDS/HIV	Diabetes	Kidney Disease
Artificial Heart Valves	Epilepsy	Liver Disease
Artificial Joints	Heart murmur	Mitral Valve Prolapse
Bleeding abnormality	Hepatitis	Osteoporosis
Breathing Problems	Hypertension	Previous Endocarditis
Cancer	Circulatory problems	Stroke
Any Infectious Diseases		Tuberculosis

List all medications you are currently taking:

_____

Allergies (circle all that apply)
Aspirin Codeine Latex Local Anesthetic Penicillin Other_____

Are you under the care of a Physician? Yes No For what condition?_____
_____
Is there anything else we should know about your Medical History? _____
_____

Women: Do you suspect that you are pregnant? Yes No Are you nursing? Yes No
Are you taking Birth Control Pills? Yes No

Dental History

Date of last checkup: _____ Date of last Dental radiographs: _____
Reason for dental checkup: _____

Check all that apply:
___ Previous Periodontal Treatment
___ Bleeding gums
___ Food collecting between teeth
___ Sensitivity to hot or cold
___ clicking or pain in jaw
___ shifting of teeth
___ Spaces between teeth when there were none before
___ Sores, growths in mouth

A change in your health status should be reported to the office at the earliest possible time.

Assignment and Release
I, the undersigned certify that I have insurance coverage with _____ and assign directly to Dr. Robert Olan all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patients signature and date _____