INNOVO
DENTAL AND IMPLANT STUDIO

Patient Registration

First Name:_____ Last Name:_____ Middle Initial: _____
Preferred Name: _____

Responsible Party (If someone OTHER than patient, please fill out below):

First Name:_____ Last Name:_____ Middle Initial: _____
Address:_____ Mailing (if different): _____
City, State, Zip Code:_____
Home Phone:_____ Cell Phone:_____ Work Phone: __
Birth Date:_____ Age:_____ Social Security#:_____
Driver's License: _____

Patient Information:

Address:_____ Mailing (if different): _____
City, State, Zip Code: _____
Home Phone:_____ Cell Phone:_____ Work Phone: _____
Birth Date:_____ Age:_____ Social Security#:_____
Driver's License: _____
Email:_____ *Would you like to receive correspondences via e-mail?* Y or N
Sex: Male ☐ or Female ☐ Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐
Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐
Student Status: ☐ Full Time ☐ Part Time ☐ Neither
Emergency Contact: _____ **Phone#:** _____

Primary Insurance Information:

Name of insured:_____ Relationship to Pt:_____
Social Security#:_____ Birth Date:_____
Employer:_____ Insurance Company: _____
Address:_____
City_____, State_____, Zip code_____

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Secondary Insurance Information:

Name of insured:_____Relationship to Pt:_____Social Security#:_____Birth Date: __	
Employer:_____	Insurance Company: _____
Address:_____	Address: _____
City, State, Zip:_____	City, State, Zip: _____

Are you under a physician's Care? .....Y N
Are you on a special Diet?..Y or N
Who is your Primary Care Doctor?_____
Do you use tobacco?..... Y N
Have you ever been hospitalized or had a major operation?...(Y) or (N)
Are you taking any medications, pills or drugs?.....(Y) or (N)
Do you take, or have you taken Phen-fen or Redux?.....(Y) or (N)
Have you ever taken Fosamax, Boniva, Actonel, or any other medications that contain biphosphonates?..... (Y) or (N)

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Are you allergic to any of the following? (Please CIRCLE if yes)
Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐
Latex ☐ Sulfa Drugs ☐ OTHER: _____

Women:

Are you pregnant/ trying to get pregnant? (Y) or (N)
Taking Oral Contraceptives? (Y) or (N) Nursing? (Y) or (N)

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Medical History

Do you have, or have you had, any of the following?

- ☐ AIDS/HIV
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy/seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives/Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Disease
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsilitis
- ☐ Tumors/Growths
- ☐ Convulsions

Do you have any other serious illness NOT listed above (Y) or (N)

Comments/Questions? Is there anything NOT listed on this form you feel we need to know?

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, OR Guardian_____Date _____