JOHN R. HOPKINS, DMD, P.C.

Phone (912) 285-3400 - Fax (912) 285-0333

PATIENT REGISTRATION AND HISTORY

Patient Information:

Name _____ Nickname _____
Marital Status _____ Birth Date _____
SS # _____ Phone (Home) _____ (Cell) _____
Street Address _____ City/State/Zip _____
If patient is student, name of school _____
Patient (or Parent's) Employer _____ Work Phone _____
Spouse (or Parent's) Name _____ Cell Phone _____
Whom may we thank for referring you _____
Person to contact in case of emergency _____

Insurance Information: (Please present insurance card at front desk.)

Name of Insured _____ Relation to Patient _____
SS # of Insured _____ Birth Date of Insured _____
Insurance Co. _____ Insurance Co. Phone _____
Insurance Co. Address _____
City/State/Zip _____ Employer _____

Dental History:

Reason for today's visit _____
Former Dentist _____ Date of Last Visit _____

Medical History:

Physician's Name _____ Date of Last Visit _____
Have you had any serious illness or operation _____
If yes, describe _____
Check if you have had any of the following:

___ Abnormal Bleeding
___ AIDS
___ Artificial Heart Valves
___ Artificial Joints
___ Asthma
___ Blood Disease
___ Cancer
___ Chemical Dependency
___ Diabetes
___ Emphysema
___ Heart Problems
___ High Blood Pressure
___ Epilepsy
___ Heart Murmur
___ HIV Positive
___ Kidney Disease
___ Liver Disease (Hepatitis)
___ Mitral Valve Prolapse
___ Radiation Treatment
___ Respiratory Disease
___ Rheumatic Fever
___ Stroke
___ Tuberculosis

List any medications you are currently taking: _____
_____

Check any allergies you may have:

___ Aspirin
___ Codeine
___ Iodine
___ Local Anesthetic
___ Penicillin
___ Sulfa

Other Allergies _____

Consent for Procedure: This is to certify that I understand and consent to the performing of the dental and oral surgery procedure agreed to be necessary or advised, including the use of local anesthetic as indicated and I will assume responsibility for fees, collection fees, and broken appointment charges. This is also to certify that the above information is true and correct to the best of my knowledge.

Patient (Parent) Signature _____ Date _____