JENNIFER KLUTH, DMD LLC 518-374-6845

PATIENT REGISTRATION & MEDICAL HISTORY

Patient Name_____ Date of Birth_____ Male__ Female ___Married __Single __
Address_____ City_____ State___ Zip_____
Home Phone _____Work Phone _____Cell Phone_____
Employer_____ Occupation_____ SS#_____
Spouse's Name_____ Spouse's Date of Birth_____
Spouse's Employer_____ Spouse's Wk Phone_____ SS#_____
Dental Insurance Name _____I.D.#_____ Group #_____
Insurance Mailing Address_____
Insured's Name_____
In case of emergency, who should be notified? _____Phone #: _____

Whom may we thank for referring you? (Please use full name)_____

MEDICAL HISTORY

Physician's Name_____ Date of Last Physical_____
Have you ever had any of the following? (Place an X by all that apply)

___	Coronary Artery Disease	___	Epilepsy	___	Immunosuppressive
		___	Chronic Headaches		Medications
___	Heart Attack	___	Stroke	___	HIV/AIDS
___	Angina	___	Cancer	___	Special Diet
___	Arrhythmia	___	Radiation Treatment	___	Recent Weight Loss
___	Mitral Valve Prolapse	___	General Allergies	___	Diabetes/Family History
___	Artificial Heart Valves	___	Allergies to Anesthetics	___	Ulcer/Colitis
___	High Blood Pressure	___	Latex Allergy	___	Swollen Neck Glands
___	Circulatory Problems	___	Respiratory Disease	___	Thyroid
___	Tonsillitis	___	Asthma	___	Rheumatic Fever
___	Arthritis	___	Sinus Problems	___	Tuberculosis
___	Artificial Joints	___	Hepatitis, Liver Disease	___	Venereal Disease
___	Osteoporosis	___	Chemical Dependency	___	Anemia/blood problems
___	Back Problems		How long in recovery_____	___	Bleeding Disorders
___	Eye Disorders	___	Psychiatric Care	___	Other_____

Do you require pre-medication before dental appointments?_____ If so, what?_____
Are you taking any anticoagulants: such as aspirin or coumadin?_____
Do you have any drug allergies or have you ever had a adverse reaction to any medication?_____
If so, what?_____ Are you taking any medications at this time?_____
Please list all medications:_____
If patient is child, what is his or her weight?_____ Do you suspect that you are pregnant?_____
If so, how many months?_____ Are you nursing?_____

THE ABOVE INFORMATION IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND IS ONLY FOR USE IN MY TREATMENT, BILLING AND PROCESSING OF INSURANCE FOR BENEFITS FOR WHICH I AM ENTITLED. I WILL NOT HOLD DR. KLUTH OR ANY MEMBER OF HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

DATE _____ SIGNATURE_____

E-Mail Address_____(to be used only for communication with our office)

Reviewed by_____Date:_____