T. GREGORY JACOBS, DDS, PA **BRYAN R. THATCHER, DMD**

PATIENT REGISTRATION FORM

NAME: _____BIRTH DATE: _____ SEX: (M F) MARITAL STATUS ( )

ADDRESS: _____CITY: _____STATE:_____ZIP CODE: _____

EMAIL: _____ HOME PHONE:_____ CELL PHONE:_____

EMPLOYER: _____ADDRESS:_____ WORK PHONE:_____

CITY: _____STATE:_____ZIP Code:_____

RESPONSIBLE PARTY:_____ADDRESS:_____PHONE NUMBER:_____

DENTAL INSURANCE: (Y N) IF YES PLEASE PRESENT INSURANCE CARD
NAME OF INSURANCE SUBSCRIBER: _____ BIRTH DATE:_____
SUBSCRIBER'S ID NUMBER: _____
REFERRED BY: _____

MEDICATION ALLERGIES_____
_____

1.	HAVE YOU HAD A HIP, KNEE OR SHOULDER JOINT REPLACEMENT (CIRCLE ONE OR ALL)	YES	NO
2.	HAVE YOU HAD AN ARTIFICIAL HEART VALVE REPLACEMENT	YES	NO
3.	ARE YOU TAKING FOSAMAX OR ANY TYPE OF MEDICATION FOR OSTEOPOROSIS	YES	NO
4.	ARE YOU ALLERGIC TO LATEX OR ANY ANESTHETICS (CIRCLE ONE OR BOTH)	YES	NO
5.	ARE YOU TAKING COUMADIN, PLAVIX, OR ANY TYPE OF BLOOD THINNERS	YES	NO
6.	DO YOU HAVE HIGH BLOOD PRESSURE, DIABETES,OR MITRAL VALVE PROLAPSE	YES	NO
7.	DO YOU TAKE ANTACIDS ON A REGULAR BASIS	YES	NO
8.	ARE YOU SUBJECT TO PROLONG BLEEDING	YES	NO
9.	DO YOU GAG EASILY GET TIRED EASILY DO YOU SNORE (CIRCLE ONE OR ALL)	YES	NO
10.	ARE YOU AWARE OR HAVE BEEN TOLD YOU STOP BREATHING DURING SLEEP	YES	NO
11.	IS YOUR SLEEP NON- REFRESHING	YES	NO
12.	ADDITIONAL MEDICAL INFORMATION:_____		
13.	WHEELCHAIR PATIENTS: PLEASE HAVE SOMEONE WITH YOU TO ASSIST IN TRANSFERRING YOU FROM YOUR WHEELCHAIR INTO THE DENTAL CHAIR		
14.	PHYSICIAN'S NAME & PHONE NUMBER: _____		
15.	PREFERRED PHARMACY NAME & PHONE NUMBER: _____		
16.	EMERGENCY CONTACT NAME & PHONE NUMBER: _____		

LIST OF MEDICATIONS

1._____2._____3._____
4._____5._____6._____

SIGNATURE:_____ Date:_____

****
OFFICE USE ONLY
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ANY MEDICAL CHANGES SINCE YOUR LAST APPOINTMENT

UPDATE:_____ UPDATE:_____ UPDATE:_____
UPDATE:_____ UPDATE:_____ UPDATE:_____
UPDATE:_____ UPDATE:_____ UPDATE:_____
UPDATE:_____ UPDATE:_____ UPDATE:_____