Clearwater DENTAL sc

715-514-5300
ClearwaterDentalEC.com

Patient Registration (PLEASE PRINT)

Email_____

Cell Phone_____

Date_____ Home Phone_____

Patient_____ (Preferred Name)_____
(Last Name) (First Name) (Initial)

Address_____City_____ State____ ZIP_____

SEX □ M □ F Age___ Birthdate_____ SS#_____ Occupation_____ Employer _____

Spouse Name_____ Occupation_____ Spouse's Employer _____

Emergency Contact Name & Phone Number_____

How did you hear about Clearwater? (**Circle all that apply**.) Family/Friend (Name) _____

Insurance Website TV Church Ad Radio Event Billboard Other _____

Medical History: Have you ever had any of the following? (Check all boxes that apply.)

□ Heart Problems
□ Pacemaker
□ Mitral Valve Prolapse
□ High Blood Pressure
□ Low Blood Pressure
□ Artificial Heart Valve
□ Artificial Joints
□ Asthma
□ Respiratory Disease
□ Liver Disease (Hepatitis, Jaundice)
□ Kidney Disease
□ Tumor or Cancer
□ Chemotherapy
□ Radiation Treatment
□ Circulatory Problems
□ Stroke
□ Diabetes
□ Ulcer, Colitis
□ Blood Disease
□ HIV / AIDS
□ Epilepsy, Seizures
□ Immunosuppressive Disorders
□ Chemical Dependency
□ Psychiatric Care
□ General Allergies
□ Latex Allergy
□ Nickel Allergy

Please list any drug/medication allergies: _____

Personal physician's name: _____Phone #: _____

Are you taking any prescription or over-the-counter medications? □ No □ Yes
Please list each one (name and dosage): _____

_____

Have you taken or are you currently taken bisphosphonates? □ No □ Yes

List any serious medical condition(s) you have ever experienced: _____

_____

Women: *Are you taking birth control pills?* □ **No** □ **Yes** *Do you suspect you are pregnant?* □ **No** □ ***Yes*** *Are you nursing?* □ **No** □ **Yes**

Patient Signature (Guardian if patient is under 18 years of age)_____ Date: _____