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☐ Digital Ad☐ Billboard☐ Other _____

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

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

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

Please list any drug/medication allergies: _____

Personal physician's name: _____Phone #: _____

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: _____