MICHAEL A. LANDAU, D.M.D.

REGISTRATION & HEALTH HISTORY

Please print clearly and answer as thoroughly as possible. In our office, we are interested in developing a complete dental health program for you. In order to do this, we must know as much about the individual as we do about your teeth. No two people are the same, no two mouths are alike. All information, of course, will be held in strict confidence.

Date _____/_____/_____

Patient's Name _____ Date of Birth _____/_____/_____
(First) (Middle) (Last)

If Child, Parent's Name _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Employed By _____

Business Phone _____ Business Address _____

Social Security No. _____

Spouse's Name _____ Date of Birth _____ Social Security No. _____

Business Phone _____ Business Address _____

Employed By _____

Person financially responsible for account _____

Do you have Dental Insurance? ☐ Yes ☐ No Insurance Co. _____

Are you covered by another Dental Insurance Plan? ☐ Yes ☐ No Insurance Co. _____

Who is your general/referring dentist? _____

_____

MEDICAL HEALTH HISTORY

Physician's Name _____ Date of Last Medical Exam _____

Have you been treated for any medical problems in the past five years?

☐ Yes ☐ No Please explain _____

Have you ever been hospitalized? ☐ Yes ☐ No If so, for what _____

_____

Are you taking any pills, drugs, or medications? ☐ Yes ☐ No

If so, please name _____

Are you allergic to any medicine or drug? ☐ Yes ☐ No

If so, please name _____

Do you take a daily aspirin? ☐ Yes ☐ No

Do you take antibiotic premedication before dental appointments? ☐ Yes ☐ No If so, for what _____

Do you have a latex allergy? ☐ Yes ☐ No

Do you have or have you ever had any of the following? Please check yes or no for each.

Yes	No		Yes	No		Yes	No	
____	____	Any Heart Problems	____	____	A.I.D.S. or H.I.V.	____	____	Stroke
____	____	High Blood Pressure	____	____	Arthritis	____	____	Venereal Disease
____	____	Low Blood Pressure	____	____	Asthma	____	____	Tuberculosis
____	____	Circulatory Problems	____	____	Anemia	____	____	Heart Attack
____	____	Radiation Treatment	____	____	Diabetes	____	____	Ulcer
____	____	Excessive Bleeing	____	____	Hepatitis	____	____	Lung Problems
____	____	Allergy to Anesthetics	____	____	Cancer/Tumors	____	____	Epilepsy/Seizures
____	____	Allergy to Medicine or Drugs	____	____	Rheumatic Fever	____	____	(Women) Are You Pregnant
____	____	Allergies to_____	____	____	Kidney Problems			
			____	____	Liver Problems	____	____	Heart Murmer

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment _____

_____

SIGNATURE _____