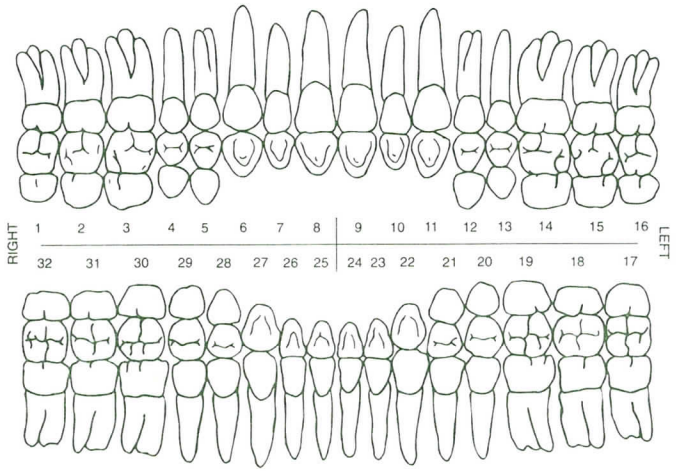
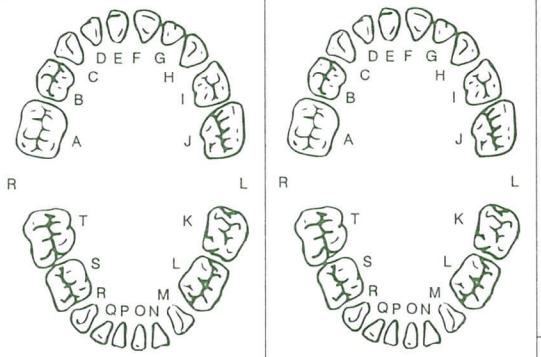
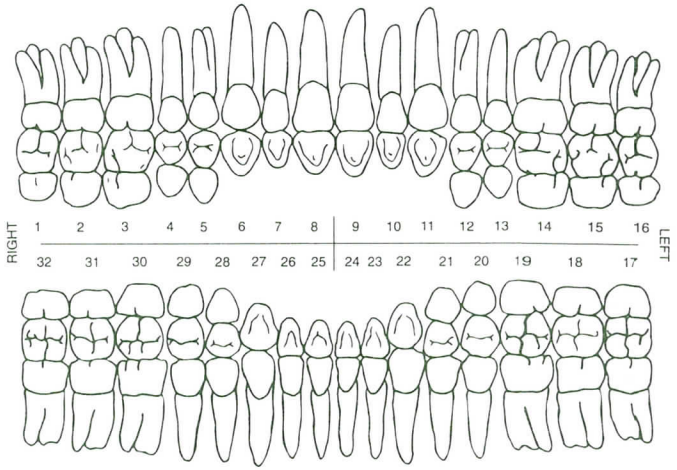
LAST NAME	FIRST NAME	RESIDENCE TEL	MAILING ADDRESS	CITY	STATE	ZIP CODE	PATIENT NO.
BILL TO		BUSNESS TEL	BUSINESS ADDRESS	CITY	STATE		DATE OF EXAM
DATE OF BIRTH	MARITAL STATUS	SEX	OCCUPATION	DENTAL INSURANCE	PHYSICIAN	RECOMMENDED BY	



CAUTIONS





CHIEF COMPLAINT _____

UNDER PHYSICIANS CARE NOW _____

MEDICATIONS _____

HOSPITALIZATIONS _____

DRUG ALLERGIES _____

REACTION TO ANESTHETICS _____

PAST OR PRESENT ILLNESSES

____ RHEUMATIC FEVER	____ EPILEPSY
____ DIABETES	____ THYROID DS
____ HEART DS	____ KIDNEY DS
____ HYPERTENSION	____ NERVOUSNESS
____ BLEEDING DS	____ ANEMIA
____ HEPATITIS	____ SINUS
____ RESPIRATORY DS	____ TONSILS
____ TUBERCULOSIS	____ OTHER
____ ALLERGY	

PT. SIG. _____ BP

PULSE

DR. SIG. _____ RESP

Patterson #200088213

ORAL FINDINGS

HYGIENE	1	2	3	4 ____
DEPOSITS	1	2	3	4 ____
PERIODT	1	2	3	4 ____

OCCLUSION _____

HABITS _____

ABNORMALITIES _____

DENTURE EXP _____

PARTIAL EXP _____

TOOTH	MOULD		SHADE	
	UPPER	LOWER	UPPER	LOWER
CENT				
LAT				
CUSP				
POST				

DATE	SERVICE PLANNED	EST. 1	EST. 2

Lewis General Dentistry Patient Registration Form