MDS MOBILE DENTISTRY SOLUTIONS
COMPASSIONATE DENTAL CARE

7575 San Felipe Suite 101 Houston, TX 77063
Phone (832) 716-0909 Fax (855) 827-7442
contact@mobiledentistrysolutions.com

NEW DENTAL PATIENT REGISTRATION & MEDICAL INFORMATION FORM

Patient Information

Last, First Name _____ Birth Date _____
Address _____ Marital Status _____
_____ Home # _____
City, State, Zip _____ Cell # _____
Email _____ Work # _____
SSN _____ Sex _____

Financial Responsible Party Information

Patient is own responsible party YES _____ NO _____
Last, First Name _____ Birth Date _____ Sex _____
Address _____ Marital Status _____
_____ Home # _____
City, State, Zip _____ Cell # _____
Email _____ Work # _____

Insurance Information

Patient has primary dental insurance YES _____ NO _____
Group No./Name _____ Subscriber Address _____
Insurance Name _____ City, State, Zip _____
Phone # _____ Relationship to Patient _____
Employer Name _____ Subscriber Birth Date _____
Subscriber Last, First _____ Subscriber ID _____

Signatures

Patient Name (print) _____ Patient Signature _____
Date _____

Responsible Party Name (print) _____ Responsible Party Signature _____
Date _____

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Medical Information

Allergic To

- [ ] Y [ ] N No Known Allergies
- [ ] Y [ ] N Aspirin
- [ ] Y [ ] N Barbiturates / Sleeping Pills
- [ ] Y [ ] N Codeine
- [ ] Y [ ] N Erythromycin
- [ ] Y [ ] N Iodine
- [ ] Y [ ] N Latex Rubber
- [ ] Y [ ] N Local Anesthetics
- [ ] Y [ ] N Metals
- [ ] Y [ ] N No Epinephrine
- [ ] Y [ ] N Penicillin
- [ ] Y [ ] N Prior Hepatitis
- [ ] Y [ ] N Sulfa Drugs
- [ ] Y [ ] N Other Narcotics

Check, if applicable

- [ ] Y [ ] N No Change Since Last Recorded
- [ ] Y [ ] N No Known Concerns or Issues
- [ ] Y [ ] N AIDS/HIV Infection
- [ ] Y [ ] N Ever use any form of tobacco?
- [ ] Y [ ] N Alcohol/Drug Abuse
- [ ] Y [ ] N Anemia / Leukemia
- [ ] Y [ ] N Ankles Swell
- [ ] Y [ ] N Anorexia / Bulimia
- [ ] Y [ ] N Arthritis
- [ ] Y [ ] N Asthma / Hay Fever
- [ ] Y [ ] N Blood Clotting Problems
- [ ] Y [ ] N Blood Transfusion
- [ ] Y [ ] N Bronchitis
- [ ] Y [ ] N Cancer / Tumor or Growth
- [ ] Y [ ] N Cardiac Pacemaker
- [ ] Y [ ] N Chest Pain Upon Exertion
- [ ] Y [ ] N Color Blindness
- [ ] Y [ ] N Contact Lenses
- [ ] Y [ ] N Damaged Heart Valve
- [ ] Y [ ] N Diabetes
- [ ] Y [ ] N Emphysema
- [ ] Y [ ] N Environmental Allergies
- [ ] Y [ ] N Epilepsy
- [ ] Y [ ] N Fainting Spells / Seizures
- [ ] Y [ ] N Fever Blisters / Herpes
- [ ] Y [ ] N Frequent Headaches
- [ ] Y [ ] N Frequently Dry Mouth / Sjogren
- [ ] Y [ ] N Gag Reflex
- [ ] Y [ ] N Gall Bladder Trouble
- [ ] Y [ ] N Heart Attack / Stroke
- [ ] Y [ ] N Heart Disease / Angina
- [ ] Y [ ] N Heart Murmur
- [ ] Y [ ] N Hepatitis / Jaundice
- [ ] Y [ ] N High Blood Pressure
- [ ] Y [ ] N Hives / Skin Rash
- [ ] Y [ ] N Joint Replacement
- [ ] Y [ ] N Kidney / Bladder Trouble
- [ ] Y [ ] N Liver Disease
- [ ] Y [ ] N Low Blood Pressure
- [ ] Y [ ] N Mental Health Problems
- [ ] Y [ ] N Mitral Valve Prolapse
- [ ] Y [ ] N Persistent Diarrhea
- [ ] Y [ ] N Premedicate
- [ ] Y [ ] N Rheumatic Fever
- [ ] Y [ ] N Rheumatic Heart Disease
- [ ] Y [ ] N Sexually Transmitted Disease
- [ ] Y [ ] N Shortness of Breath
- [ ] Y [ ] N Sinus Trouble
- [ ] Y [ ] N Stomach Ulcers
- [ ] Y [ ] N Thyroid Problems
- [ ] Y [ ] N Tuberculosis
- [ ] Y [ ] N Unusual Weight Loss
- [ ] Y [ ] N Urinate Frequently

Other

- [ ] Y [ ] N See Scanned Documents: Pt Note

Have you ever taken oral bisphosphonates or IV bisphosphonates (ex: Fosamax, Actonel, Boniva, Zometa, Aredia, Didronel, Skelid, Reclast)? _____ If yes, for how long: _____

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Physician Info

Physician Type	Physician's Name	Physician's Phone #:
Primary Care		
Cardiologist		
Neurologist		

Hospitalizations

Date	Reason(s)

Prescription Medications

#	Drug Name and Quantity	#	Drug Name and Quantity
1		6	
2		7	
3		8	
4		9	
5		10	

If necessary….Please attach a separate sheet for more room

Signature

	/ /
Signature of Patient or Responsible Party (if Applicable)	**Date**

My signature above indicates that I have provided the most accurate patient information possible and assume responsibility for inaccuracies and omissions.

Responsible Party Info:

			/ /	
First	**M I**	**Last Name**	**DOB**	**M or F**

Relationship to the Patient: ☐ *Son* ☐ *Daughter* ☐ *Husband* ☐ *Wife* ☐ *Relative* ☐ *Other*