Sunshine Dental Care Registration

28755 Dequindre Rd

Madison Heights, Mi 48071 Date _____

Patient Name _____ Date of Birth _____ SC#_____

Address _____City _____ State _____ Zip_____

Gender: Male __ Female ___ Marital Status: Single __ Married__ Widow__ Divorced___ Separated_____

Cell Phone #_____ Second phone#_____ Email_____

Emergency contact Person_____ Relationship _____ Phone#_____

If the patient is under the age of 18, please provide information for the parent or legal guardian:

Parent/legal guardian Name_____ Phone#_____

If you have Insurance:

Insurance company_____ Id#_____ Group#_____

Policy Holder's Name _____ Policy Holder's DOB: _____

Policy Holder's Employer _____ Relationship to patient_____

Primary care physician_____ PCP phone#_____

Preferred Pharmacy _____ Preferred Pharmacy Phone# _____

Secondary insurance

Insurance company_____ Id#_____ Group#_____

Policy Holder's Name _____ Policy Holder's DOB: _____

Policy Holder's Employer _____ Relationship to patient_____

Primary care physician_____ PCP phone#_____

Preferred Pharmacy _____ Preferred Pharmacy Phone# _____

Medical Report:

Reason for visit _____

Medical History

0 Breathing problems	0 Heart problems	0 Current wound	0 Tumor/Cancer	0 Bone/Joint problems
0 High blood pressure	0 Gallbladder/Liver	0 Kidney Problems	0 Pregnant	0 History of heavy alcohol use
0 Smoking	0 Drug use	0 Headaches	0 Diabetes	0 Others

Please List Any current or past medical problems and Approximate dates _____

_____

Please List all current medications, dosage, and duration_____

Please list any allergies to medications 0 Lates 0 Codeine 0 Aspirin 0 Other_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand than providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, Parent or Guardian _____ Date_____