TIMOTHY P. BARKLEY, D.D.S.

8678 LOUETTA RD. SUITE, B
SPRING, TX 77379

Patient Registration
(Please print)

Date_____

Name:(LAST)_____(FIRST)_____(MI)_____

Preferred Name:_____Email Address:_____

Home Phone:_____ Cell Phone:_____

Street Address:_____

Apt #:_____City:_____State:_____Zip:_____

Sex:M_____F_____ Marital Status: Single_____Married_____Divorced_____

Driver's License # & State:_____

Date of Birth:_____/_____/_____ Social Security #_____-_____-_____

Employer:_____Business Phone:_____

Spouse's Name:_____

Spouse's Employer:_____Business Phone:_____

Spouse's Birthdate:_____/____/_____ Spouse's Social Security #_____-_____-_____

Name of Dental Insurance Company:_____

Group #_____Member ID #_____

Whom may we thank for referring you?_____

PLEASE FILL OUT MEDICAL HISTORY ON BACK SIDE

Although dental personnel primarily treat the area in and around the mouth, your mouth is part of your entire body. Health problems that you may have or medications that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Physican's Name:_____Date of Last Physical:_____

Have you ever had the following:

____Y____N AIDS/HIV Positive	**____Y____N Epilepsy or Seizures**	**____Y____N Liver Disease**
____Y____N Alzheimer's Disease	**____Y____N Excessive Bleeding**	**____Y____N LowBloodPressure**
____Y____N Anemia	**____Y____N Fainting Spells/Dizziness**	**____Y____N Lung Disease**
____Y____N Angina	**____Y____N Frequent Cough**	**____Y____N MitralValve Prolapse**
____Y____N Arthritis/Gout	**____Y____N Frequent Diarrhea**	**____Y____N Pain in Jaw Joints**
____Y____N Artificial Heart Valve	**____Y____N Frequent Headaches**	**____Y____N Parathyroid Disease**
____Y____N Artificial Joint	**____Y____N Genital Herpes**	**____Y____N Psychiatric Care**
____Y____N Asthma	**____Y____N Glaucoma**	**____Y____N Recent Weight Loss**
____Y____N Blood Disease	**____Y____N Hay Fever**	**____Y____N Renal Dialysis**
____Y____N Blood Transfusion	**____Y____N Heart Attack**	**____Y____N Rheumatism**
____Y____N Cancer	**____Y____N Heart Murmur**	**____Y____N Sickle Cell Disease**
____Y____N Chemotherapy	**____Y____N Heart Pace Maker**	**____Y____N Sinus Trouble**
____Y____N Chest Pains	**____Y____N Heart Disease**	**____Y____N Spina Bifida**
____Y____N Cold Sores/Fever Blisters	**____Y____N Hemophilia**	**____Y____N Stroke**
____Y____N Congenital Heart Disorder	**____Y____N Hepatitis A**	**____Y____N Thyroid Disease**
____Y____N Convulsions	**____Y____N Hepatitis B or C**	**____Y____N Tonsillitis**
____Y____N Cortisone Medicine	**____Y____N High Blood Pressure**	**____Y____N Tuberculosis**
____Y____N Diabetes	**____Y____N Hives or Rash**	**____Y____N Tumors or Growths**
____Y____N Drug Addiction	**____Y____N Hypoglycemia**	**____Y____N Ulcers**
____Y____N Emphysema	**____Y____N Leukemia**	**____Y____N Yellow Jaundice**

Are you allergic to any of the following? Asprin____Penicillin____Codeine____Sulfa Drugs_____
Acrylic____ Metal____Latex____Local Anesthetics____Other_____
Have you ever responded adversely to medical or dental treatment? If so, please describe_____
_____
Are you apprehensive of dental treatment and need sedation?_____
Please list all (including over the counter)medications you are currently taking or have taken in the past 2 weeks:_____
If the patient is a child, what is his/her weight?_____
(Women)Are you or do you suspect you are pregnant?_____Are you nursing_____
Is there anything else we need to know about your medical or dental history?_____
_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any staff member responsible for any errors or omissions that I may have made in the completion of this form.

Date:_____Signature:_____