LANDMARK DENTAL CARE

Patient Registration Form

First Name: Middle Initial: Last Name:
Birth Date: Social Security Number:
Address:
City, State, Zip:
Home Phone: Work Phone:
Cell Phone: E-mail:
How did you hear about us?

Please check the box if you are the:
- ☐ Responsible Party (Must be 18 years or older)
- ☐ Insurance Policy Holder
- ☐ Student Full Time ☐ Student Part Time

If you are not the responsible party please complete the following section.
Name:
Relationship to Patient:
Birth Date:
Social Security #:
Address:
City, State, Zip:
Phone #:

Primary Insurance Information
Insurance Company: Employer:
Policy Holder Name: ID #:
Group Number: Insurance Phone #:

Secondary Insurance Information
Insurance Company: Employer:
Policy Holder Name: ID #:
Group Number: Insurance Phone #:

If you are not the policy holder, please complete the following section.

Primary Insurance Policy Holder N/A ☐
Name:
Relationship:
Birth Date:
Social Security #:
Address:
City, State, Zip:
Phone #:

Secondary Insurance Policy Holder N/A ☐
Name:
Relationship:
Birth Date:
Social Security #:
Address:
City, State, Zip:
Phone #:

Medical History Form

Name: Birth date (MM/DD/YYYY):

Have you ever been hospitalized or had a major operation?
If yes, please explain:

Have you ever had a serious head or neck injury?
If yes, please explain:

Are you taking any medications, pills or drugs?
If yes, please explain:

Are you on a special diet?
Do you use tobacco?
Do you use controlled substances?

Are you pregnant/trying to get pregnant?
Are you nursing?
Are you taking oral-contraceptives?

Are you allergic to any of the following:

- ☐ Aspirin ☐ Penicillin
- ☐ Codeine ☐ Local Anesthetics
- ☐ Acrylic ☐ Metal
- ☐ Latex ☐ Other

If you chose other, please explain:

Do you have or have you had, any of the following?

AIDS/HIV Positive		Kidney Problems		Frequent Diarrhea	
Alzheimer's Disease		Leukemia		Frequent Headaches	
anaphylaxis		Liver Disease		Genital Herpes	
Anemia		Low Blood Pressure		Glaucoma	
Angina		Lung Disease		Hay Fever	
Arthritis/Gout		Mitral Valve Prolapse		Heart Attack/Failure	
Artificial Heart Valve		Pain in Jaw Joints		Heart Murmur	
Artificial Joint		Parathyroid Disease		Heart Pace Maker	
Asthma		Psychiatric Care		Heart Trouble/Disease	
Blood Disease		Radiation Treatments		Hemophilia	
Blood Transfusion		Recent Weight Loss		Hepatitis A	
Breathing Problem		Renal Dialysis		Hepatitis B or C	
Bruise Easily		Rheumatic Fever		Herpes	
Cancer		Rheumatism		Sinus Trouble	
Chemotherapy		Scarlet Fever		Spina Bifida	
Chest Pains		Shingles		Stomach/Intestinal Disease	
Cold Sores/Fever Blisters		Sickle Cell Disease		Stroke	
Congenital Heart Disorder		Drug Addiction		Swelling of Limbs	
Convulsions		Easily Winded		Thyroid Disease	
Cortisone Medicine		Emphysema		Tonsillitis	
Diabetes		Epilepsy or Seizures		Tuberculosis	
High Blood Pressure		Excessive Bleeding		Tumors or Growths	
Hives or Rash		Excessive Thirst		Ulcers	
Hypoglycemia		Fainting Spells/Dizziness		Venereal Disease	
Irregular Heartbeat		Frequent Cough		Yellow Jaundice	

Have you had any serious illness not listed above
If yes, please explain:

Landmark Dental Care
Harvey Weener, D.D.S., P.L.L.C.
283 Broad Street, Nashua, NH 03063
Tel: (603)882-7312 Fax: (603)594-8824
www.landmarkdentalnashua.com

Record Release Request

I, , request that send my x-rays and dental records to:

Landmark Dental Care
283 Broad Street
Nashua, NH 03063
(603)882-7312

info@landmarkdentalnashua.com
Fax: (603)594-8824

Patient/Guardian Signature Date
Telephone number where I can be reached:

Submit by Email Print Form