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PATIENT REGISTRATION FORM

Please print

PERSONAL INFORMATION:

Date _____

Name _____ Birth Date _____ Sex _____
First M.I. Last

Address _____
Street Address Apt# City State Zip

Phone: (Day) _____ (Eve) _____ (Cell) _____
Area code Number Area code Number Area code Number

Marital Status _____ Race _____ Education _____

Spouse/Sig. Other _____
Name Phone

Employer _____ Phone _____ Occupation _____
(patient or parent)

Referred by _____ Responsible party (if minor) _____

Allergies _____

INSURANCE INFORMATION:

Insurance Co _____ Group # _____ Policy # _____

Insured Name _____ Birth Date _____ Sex _____
First M.I. Last

Insured Address _____
Street Address Apt# City State Zip

Phone: (Day) _____ (Eve.) _____ SS# _____ - _____

FAMILY HISTORY: If any blood relative has suffered any of the following, please indicate which relative.

Allergies _____ Asthma _____ Anemia _____ Arthritis _____ Alcoholism _____

Blood Clotting Problems _____ Cancer _____ Diabetes _____ Epilepsy _____

Glaucoma _____ Genetic Disease _____ Gout _____ Headaches _____

Heart Disease _____ High Blood Pressure _____ Kidney/Bladder Problem _____

Mental Illness _____ Stroke _____ Tuberculosis _____ Other _____

DENTAL HISTORY:

Extractions no yes # of teeth _____ **Root Canals** no yes **Implants** no yes

Bridges no yes (upper lower) Does any bridge cross the midline? no yes

Dentures upper lower partial Age last fitted _____

Do you currently or did you have: overbite under bite crooked teeth buck teeth

Orthodontia no yes, age _____ Reason for orthodontia: _____

Temporomandibular Joint (TMJ): splints no yes (upper lower)
surgery no yes (left right)

