New Patient Registration

Name: _____ DOB: _____

E-mail address: _____ Phone: _____

How did you hear about our office? _____ Method of Contact: _____
Phone or E-mail

Address: _____
Street City State Zip

Telephone: _____
Home Work Cell

Person Responsible for Account (please check one): ❒Patient ❒Spouse ❒Parent

Name: _____ Telephone: _____ Driver's Lic#: _____

Address: _____
Street City State Zip

SSN: _____ Employer: _____ Work Phone: _____

Primary Insurance Information

Name of Insured: _____

Relationship to patient: _____

DOB: _____ SSN: _____

Employer: _____

Employer Address: _____

_____

Insurance Company: _____

Group #: _____

Policy/ID # _____

Secondary Insurance Information

Name of Insured: _____

Relationship to patient: _____

DOB: _____ SSN: _____

Employer: _____

Employer Address: _____

_____

Insurance Company: _____

Group #: _____

Policy/ID # _____

Emergency Contact Information: Name: _____

Address: _____ Phone: _____

As a courtesy to you, we strive to be accurate in our estimations. However, these are only estimations. Ultimately you are responsible for the total balance due to our office. Thank you!

Authorization: I understand I am responsible for all costs of dental treatment. The information on this page and the dental/medical histories are correct to the best of my knowledge. I acknowledge I have received and read the Consent, Privacy Policy forms, HIPAA and the Dental Material Fact Sheet.

_____

Patient or Responsible Party **Date**

Medical History

Patient Name: _____

Have you ever been hospitalized or had a major operation?	Yes____ No ____ if yes, please explain_____
Have you had any major neck/head injury?	Yes____ No ____ if yes, please explain _____
Are you currently taking any medications or vitamins?	Yes____ No ____ if yes, please list:_____
Do you take, or have taken, Phen-Fen or Redux?	Yes____ No ____
Do you take/have you taken a Bisphosphonate (Fosamax)?	Yes____ No ____ if yes, please list: _____
Are you on a special diet?	Yes____ No ____
Do you use tobacco?	Yes____ No ____
Do you use controlled substances?	Yes____ No____

Physician's Name: _____

Date of last Physical: _____

Please mark any of the following that you are allergic to:

_____ Aspirin _____ Penicillin _____ Codeine _____ Acrylic _____Latex _____ Metal _____Local Anesthetics
_____Sulfa _____Other (Please explain):_____

For Women:

Are you pregnant/trying to get pregnant? Yes___ No ___ Taking oral contraceptives? Yes___ No ___ Nursing? Yes___ No ____

Do you have, or have you had any of the following? (Please be sure to mark either "yes" or "no")

Yes___ No ___ AIDS/HIV Positive
Yes___ No ___Alzheimer's Disease
Yes___ No ___ Anaphylaxis
Yes___ No ___ Anemia
Yes___ No ___ Angina
Yes___ No ___ Arthritis/Gout
Yes___ No ___ Artificial Heart Valve
Yes___ No ___ Artificial Joint
Yes___ No ___ Asthma
Yes___ No ___ Blood Disease
Yes___ No ___ Blood Transfusion
Yes___ No ___ Breathing Problem
Yes___ No ___ Bruise Easily
Yes___ No ___ Cancer
Yes___ No ___ Chemotherapy
Yes___ No ___ Chest Pains
Yes___ No ___ Cold Sores
Yes___ No ___ Cong. Heart Disorder
Yes___ No ___ Convulsions
Yes___ No ___ Cortisone Medicine
Yes___ No ___ Diabetes
Yes___ No ___ Drug Addiction
Yes___ No ___ Easily Winded
Yes___ No ___ Emphysema (COPD)
Yes___ No ___ Epilepsy or Seizures

Yes___ No ___ Excessive Bleeding
Yes___ No ___ Excessive Thirst
Yes___ No ___ Fainting/Dizziness
Yes___ No ___ Frequent Cough
Yes___ No ___ Frequent Diarrhea
Yes___ No ___ Genital Herpes
Yes___ No ___ Glaucoma
Yes___ No ___ Hay Fever
Yes___ No ___ Heart Attack/Failure
Yes___ No ___ Heart Murmur
Yes___ No ___ Heart Pacemaker
Yes___ No ___ Heart Trouble/Disease
Yes___ No ___ Hemophilia
Yes___ No ___ Hepatitis A
Yes___ No ___ Hepatitis B or C
Yes___ No ___ Herpes
Yes___ No ___ High Blood Pressure
Yes___ No ___ High Cholesterol
Yes___ No ___ Hives/Rash
Yes___ No ___ Hypoglycemia
Yes___ No ___ Irregular Heartbeat
Yes___ No ___ Kidney Problems
Yes___ No ___ Leukemia
Yes___ No ___ Liver Disease
Yes___ No ___ Low Blood Pressure
Yes___ No ___ Lung Disease

Yes___ No ___ Mitral Valve Prolapse
Yes___ No ___ Osteoporosis
Yes___ No ___ Pain in Jaw Joints
Yes___ No ___ Parathyroid Disease
Yes___ No ___ Psychiatric Care
Yes___ No ___ Radiation Treatments
Yes___ No ___ Recent Weight Loss
Yes___ No ___ Renal Dialysis
Yes___ No ___ Rheumatic Fever
Yes___ No ___ Rheumatism
Yes___ No ___ Scarlet Fever
Yes___ No ___ Shingles
Yes___ No ___ Sickle Cell Disease
Yes___ No ___ Sinus Trouble
Yes___ No ___ Spina Bifida
Yes___ No ___ Stomach Disease
Yes___ No ___ Stroke
Yes___ No ___ Swelling of Limbs
Yes___ No ___ Thyroid Disease
Yes___ No ___ Tonsillitis
Yes___ No ___ Tumors/Growths
Yes___ No ___ Ulcers
Yes___ No ___ Venereal Disease
Yes___ No ___ Yellow Jaundice

Have you ever had any serious illness not listed above? Yes___ No_____ If so, please explain: _____

Additional Comments:_____

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

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN:_____ DATE:_____

Dental History

Patient Name:_____

Previous Dentist Information

Prev. Dentist Name:_____ Prev. Dentist Phone:_____

Date of Last Dental Appointment:_____

May we inquire why you left your previous dentist? _____

Family History

Please mark if you have any of the following disease history in your family:

_____ Cancer _____ Heart Disease _____ Diabetes _____ Nerve Disease _____ Nervous Disorders

___ Yes ___ No Are you currently experiencing any dental pain?
___ Yes ___ No Are you having any current sensitivity to hold/cold?
___ Yes ___ No Have you had any head, neck, or face injuries?
___ Yes ___ No Have you had any previous orthodontic treatment?
___ Yes ___ No Have you ever received oral hygiene instructions for care of teeth and gums?
___ Yes ___ No Have you experienced any clicking/pain/or difficulty opening or closing your jaw?
___ Yes ___ No Have you ever been diagnosed with periodontal (gum) disease?
___ Yes ___ No Are you interested in a straighter smile?
___ Yes ___ No Are you interested in a whiter smile?
___ Yes ___ No Do you enjoy your smile?

Are you required to pre-medicate before dental procedures? Yes_____ No _____

What kind of toothpaste do you use? _____

Do you use a manual or electric toothbrush?
_____

How often do you floss? _____

Describe your oral hygiene routine: _____

What are your dental concerns?
_____

_____