

NEW PATIENT REGISTRATION FORM



ABOUT YOU

Today's Date _____

Name _____ I prefer to be called _____
First Last

Home Address _____
Address City, State Zip

Do you: Rent Own Are you: Single Married Divorced Widowed Separated

Phone () _____ | () _____ | () _____
Home Work Mobile

Email _____ What is the best way to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us? _____

Employer _____ How long there? _____ Occupation _____

Spouse's Name (if applicable) _____ Spouse's Employer _____

Who should we contact in case of emergency? _____ () _____
Name Phone

Who is responsible for this account? _____

DENTAL INSURANCE INFORMATION

Insurance Company Name _____

Group # _____ Phone () _____

Insurance Company's Address: _____
Address City, State Zip

Insured's Name: _____ Insured's Soc. Sec. # _____

Insured's Birthdate _____ Insured's Employer _____

Relationship to you _____ Do you have secondary insurance? Yes No

DENTAL HISTORY

Why have you come to the dentist today? _____

When was your last dental visit? _____ Are you currently in pain? Yes No

Do you require antibiotics before dental treatment? Yes No Your current dental health is: Good Fair Poor

Would you like fresher breath? Yes No Are your teeth sensitive to hot, cold, or pressure? Yes No

Do your gums ever bleed? Yes No

Have you ever had any serious complications with previous dental treatment? Yes No

If so, please describe _____

Is there a reason you would like us to know why you left your previous dentist? _____

If you could change your smile, would you (check all that apply):

- Make it whiter Make it straighter Close spaces Replace old metal fillings Replace chipped teeth
 Replace missing teeth Replace old crowns that don't match Have a smile makeover

On a scale of 1-10, with 10 being the highest:

| | | | | | | | | | | |
|--|---|---|---|---|---|---|---|---|---|----|
| How important is your dental health to you? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Where would you rate your current dental health? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Where do you want your dental health to be? | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

MEDICAL HISTORY

Physician's Name _____ Phone (____) _____

Date of last visit: _____ Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

If yes, please explain: _____

Are you allergic to any of the following? (check all that apply)

- Penicillin Metals/Jewelry Aspirin Erythromycin Latex Dental Anesthetics Sulfa Drugs
 Codeine Other _____

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

| | | | | | | | |
|---------------------|-------|-------------------|-------|--------------------------|-------|-----------------------|-------|
| Abnormal Bleeding | Y / N | Pacemaker | Y / N | Heart Surgery | Y / N | Emphysema | Y / N |
| Arthritis | Y / N | Rheumatic Fever | Y / N | HIV/AIDS | Y / N | Fever Blisters | Y / N |
| Cancer/Malignancy | Y / N | Tuberculosis | Y / N | Low Blood Pressure | Y / N | Heart Attack | Y / N |
| Diabetes | Y / N | Alcohol Abuse | Y / N | Radiation Treatment | Y / N | Hepatitis | Y / N |
| Epilepsy | Y / N | Artificial Joints | Y / N | Seizures | Y / N | Kidney Problems | Y / N |
| Glaucoma | Y / N | Chemotherapy | Y / N | Ulcers | Y / N | Mitral Valve Prolapse | Y / N |
| Heart Murmur | Y / N | Drug Abuse | Y / N | Anemia | Y / N | Osteoporosis | Y / N |
| High Blood Pressure | Y / N | Fainting Spells | Y / N | Asthma | Y / N | Stroke | Y / N |
| Liver Disease | Y / N | Migraines | Y / N | Congenital Heart Disease | Y / N | Venereal Disease | Y / N |

Please list any serious medical conditions you have experienced: _____

Are you taking any prescription or over the counter drugs? Yes No

If so, please list: _____

Do you smoke or use tobacco in another form? Yes No

Do you take a daily aspirin or any blood thinners? Yes No

WOMEN:

Are you currently pregnant? Yes No If so, how many weeks? _____

Are you taking birth control pills? Yes No

Are you taking/have you taken medication for osteoporosis? Yes No

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need.

I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

Signature _____ Date _____