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NEW PATIENT REGISTRATION FORM

Date: _____

Patient's Name (Last)_____ (First) _____(MI) _____

(Nickname)_____ If a child, parents' name: _____

Street Address: _____

City: _____ State: _____Zip: _____

Phone:_____ Cell Phone: _____

Email Address:_____

Emergency Contact Name: _____ Phone: _____

Insurance Company:_____ Group/Policy # _____

Employer: _____ Present Position: _____

Business Address: _____ Phone: _____

How did you find us? _____ Whom may we thank for referring you? _____

MEDICAL HISTORY

Date of Birth: _____ Age:_____ Social Security # _____

Physician's Name:_____ Phone: _____

Physician's Address: _____

When did you last see your Physician? _____ What for? _____

Please list any previous/current medical problems that you have, and treatment(s) you are receiving:____

_____

What medications, if any are you allergic to? _____

_____

What medications (including vitamins/supplements) are you currently taking?_____

_____

Have you been hospitalized in the last ten years? Explain when and why:_____

_____

If you have, or have had any of the following, please check all that apply and explain where indicated:

- ❑ Allergies to things other than medications (i.e. seasonal, food, detergents) _____

_____

- ❑ Heart Problems
- ❑ Heart Murmur (diagnosed when?)_____
- ❑ Heart Valve Surgery (when?) _____
- ❑ Knee or Hip Replacement (when?) _____
- ❑ High blood pressure/hypertension (when were you last checked?) _____
- ❑ Bleeding Problems (type?)_____
- ❑ Rheumatic Fever
- ❑ Diabetes (type, diagnosed when?)_____
- ❑ Hepatitis (type, diagnosed when?) _____
- ❑ Sexually transmitted disease (type, diagnosed when?) _____
- ❑ HIV / AIDS (diagnosed when?) _____
- ❑ Depression (diagnosed when?) _____
- ❑ Other psychiatric disorders (type, diagnosed when?) _____
- ❑ Eating disorders (type, diagnosed when?) _____
- ❑ Cancer (type, diagnosed when?) _____
- ❑ Drug addiction history (yes/no, how much, how long?)_____
- ❑ Alcohol (average daily consumption per day/week?) _____
- ❑ Tobacco/Smoking history (yes/no, how much, how long?) _____
- ❑ Currently pregnant (yes/no, how many weeks?)_____

DENTAL HISTORY

When was the last time you sent to a dentist? _____

What treatment did you receive? _____

When was your last teeth cleaning? _____

Did you receive xrays at that visit (yes/no, type?) _____

If no, have you had dental xrays in the past 1-5 years? (yes/no, type or #)

Do you have dental pain today? (explain) _____

_____

Do you have any other dental concerns today? _____

_____

Please check all that apply and explain where indicated:

- ❑ Sensitivity (hot/cold/acidic/sweet?) _____
- ❑ Recession
- ❑ Clenching/Grinding
- ❑ TMJ Concerns (soreness, headaches, popping, etc?) _____
- ❑ Nightguard
- ❑ Orthodontics (what and when?)_____
- ❑ Dental Surgeries(what and when?) _____
- ❑ Removable Appliances (type?) _____
- ❑ Fixed Dental Bridges
- ❑ Dental Implants
- ❑ Bleeding Gums
- ❑ Daily Brushing (how often?) _____
- ❑ Flossing Habit (how often?) _____
- ❑ Sonicare or Electric Toothbrush
- ❑ Waterpik
- ❑ Mouthwash (how often?)_____
- ❑ Dental Phobia (explain)_____

_____

How would you like to receive appointment reminders?

❑ Email _____ ❑ Text _____ ❑ Regular Mail

Provide address Provide Cell #

Print Name: _____ Signature: _____