

New Patient Registration

Patient Information

Today's Date: _____ Date of Birth: _____ Social Security Number (SSN): _____
Patient's Name: _____ Home Phone: _____ Cell Phone: _____
Address: _____
City: _____ State: _____ Zip: _____ Work Phone: _____ Ext.: _____
How do you wish to be addressed? _____ E-Mail: _____
Employer: _____ Position: _____ How Long: _____
Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Spouse's Name: _____ Date of Birth: _____
Spouse's Employer: _____ SSN: _____
Name of Person Responsible for this acct? _____
Whom may we thank for this referral? _____
Someone to notify in case of emergency: _____ Phone: _____

Dental Insurance

1st Coverage

Employee Name: _____
Date of Birth: _____ SSN: _____
Employer: _____ Yrs: _____
Ins. Co. Name: _____
Co. Address: _____
Phone No.: _____
Policy / Group No.: _____

2nd Coverage

Employee Name: _____
Date of Birth: _____ SSN: _____
Employer: _____ Yrs: _____
Ins. Co. Name: _____
Co. Address: _____
Phone No.: _____
Policy / Group No.: _____

Dental History

What is the purpose of this visit? _____
Do you have a specific dental problem that needs attention now? _____
What is it? _____
How long has it been since your last dental visit? _____
How long has it been since your last dental cleaning? _____
Have you had any dental X-rays taken recently? _____ When: _____
Who was your previous dentist? _____
Address: _____
Telephone: _____
Do you clench or grind your teeth? _____ Does your jaw click or pop? _____
Have you experienced any pain or soreness in the muscles of your face or ear? ☐ yes ☐ no
Does food get caught between your teeth? ☐ yes ☐ no
Are any of your teeth sensitive to ☐ heat ☐ cold ☐ sweets ☐ pressure?
How often do you brush? _____ How often do you floss? _____

New Patient Registration

Patient's Name: _____ Today's Date: _____

Dental History - Continued

Do your gums bleed or hurt when brushing or flossing? _____

Have you had any previous gum surgery? ☐ yes ☐ no When? _____

Has anyone told you that your breath is offensive? _____

Are you happy with the appearance of your teeth? _____

Have you had any unpleasant dental experiences? _____

Do you have questions or concerns? _____

Medical History

When was your last complete physical exam? _____ Reason: _____

Physician's Name: _____ Phone: _____

Have you been hospitalized in the last 5 years? _____ Reason: _____

Are you currently taking any medication? _____

Please list: _____

Have you ever taken Fosamax or any other osteoporosis medications? _____ If yes, what? _____

Are you allergic to or have you had any adverse reaction to any medication? _____

Are you allergic to penicillin or other drugs? _____ Are you allergic to anesthetic or latex? _____

Do you have, have you ever been treated for, or have you ever been told you might have:

YES	NO	YES	NO	YES	NO	YES	NO
☐	☐	☐	☐	☐	☐	☐	☐
Artificial Joint		Low Blood Pressure		Kidney Disease		Anemia	
☐	☐	☐	☐	☐	☐	☐	☐
Heart Valve Implant		Stroke		Jaundice		Respiratory Disease	
☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease		Radiation Treatment		Herpes 1		Fainting Spells	
☐	☐	☐	☐	☐	☐	☐	☐
Rheumatic Fever		Cancer		Herpes 2		HIV	
☐	☐	☐	☐	☐	☐	☐	☐
Heart Murmur		Asthma		Epilepsy		Menopause	
☐	☐	☐	☐	☐	☐	☐	☐
Mitral Valve Prolapse		Hives		Arthritis		Hepatitis Type: _____	
☐	☐	☐	☐	☐	☐	When: _____	
High Blood Pressure		Diabetes		Tuberculosis			

Are you pregnant? _____ Do you smoke? _____ Do you consume alcoholic beverages? _____

Have you ever bled excessively after being cut or wounded? _____

Have you ever tested positive for HIV? _____

Have you ever had any other serious medical problem? _____

Explain: _____

Is there anything else we should know about your health? _____

Authorization and Release

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Signature of Patient _____ Date _____

Office Use Only

Date	Update	Initials
_____	_____	_____
_____	_____	_____