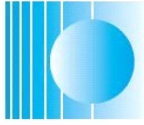

NEW PATIENT REGISTRATION

PATIENT / CONTACT INFORMATION

Patient Name: ____ Gender: _______________________

Date of Birth: __________________________________ SSN: ____________________________

Check One: _____ Married ______ Single ______ Divorced ______ Widowed

Address: ____

Street Apt. #

____

City State Zip

Cell: ___________________ Home: __________________ Work: _______________ Ext: ________

Email: ____

Emergency Contact: ________________________ Phone: _________________ Relationship: __________

REFERRAL INFORMATION / HOW DID YOU HEAR ABOUT OUR PRACTICE?

Friend/Family Members Name: ____ or,

____ Google ____ Internet ____ Yelp ____ Walk-In ____ Live/Work in Neighborhood
____ ZocDoc ____ Referred by Dr. ________________________ ____ Other: ________________

EMPLOYMENT INFORMATION

Employer Name: _______________________________ Phone Number: ___________________

INSURANCE INFORMATION

Name of **Primary** Dental Insurance Carrier: ____

Subscriber Name: _________________________________ Subscriber DOB: ___________________

Subscriber Address: ____

Subscriber SSN: _______________________________________ Relationship to Patient: ______________

ID Number: _________________________________ Group Number: ______________________________

Name of **Secondary** Dental Insurance Carrier: ____

Subscriber Name: _________________________________ Subscriber DOB: ___________________

Subscriber Address: ____

Subscriber SSN: _______________________________________ Relationship to Patient: ______________

ID Number: _________________________________ Group Number: _______________________________

For a Very Limited Amount of Procedures, we **may be able to/have to submit to your medical insurance:*

Name of **Medical** Insurance Carrier: ____

Subscriber Name: _________________________________ Subscriber DOB: ___________________

Subscriber Address: ____

Subscriber SSN: _______________________________________ Relationship to Patient: ______________

ID Number: _________________________________ Group Number: _______________________________

General Health History

Name of General Physician: _________________________________ Tel: __________________________

Date of Last Physical Exam: ____________________ Allergies: __________________________________

____

Daily Medications/Dosages: ____

____

Name of Pharmacy: ______________________ Pharmacy Phone Number: _______________________

Pharmacy Address: ____

Past Surgery/Joint Replacement History: ____

Do you pre-medicate w/ an antibiotic for dental visits? If yes, which? ____________________________

PLEASE CHECK ANY THAT APPLY:

Anemia
Heart Condition
Pacemaker
Artificial Heart Valve
Mitral Valve Prolapse
Thyroid Problems
High Blood Pressure
Low Blood Pressure
Diabetes
Liver Disease
Kidney Failure
Multiple Sclerosis
Fainting Spells

Anxiety / Mental Illness
Gallbladder Disease
Cancer History
Chemo/Radiation
Bleeding/Clotting Issues/Hx of Blood Transfusions
Asthma
AIDS/HIV+
Autoimmune Disease
Glaucoma / Eye Disease
Stroke History
Tobacco Usage (Current or Former)
Controlled Substance/Drug Usage

Alcohol Usage (____ drinks/week)
Circulatory Problems
Hepatitis
Tuberculosis
Gastrointestinal Issues/Ulcers/Chron’s Disease
Epilepsy
Headaches / Migraine
Parkinsons Disease
Sleep Apnea
Arthritis
Dementia/Alzheimers Disease
Bone Density/Osteo Disease

DENTAL HISTORY

Previous/Referring Dentist: ________________________________ Phone: _________________________

Address: ____

Most Recent Exam: _______________ Cleanings: _________________ X-Rays: __________________

What are your immediate dental concerns? ____

Are you happy with the appearance of your smile? Circle One: Yes / No

Would you like to discuss enhancing the appearance of your smile? Circle One: Yes / No

Would you like to discuss options for teeth whitening? Circle One: Yes / No

Have you undergone prior orthodontic (braces) treatment? Circle One: Yes / No

If yes, are you wearing a retainer? Circle One: Yes / No Comments: _____________________________

Would you like to discuss straightening/correcting alignment of your smile? Circle One: Yes / No

Check if you have had problems with any of the following:

Bad Breath
Bleeding Gums
Clicking/Popping Jaw
Grinding/Clenching Teeth

Food Collection
Loose Teeth
Broken Fillings
Jaw Pain/Facial Ache

Periodontal/Gum Disease
Sensitivity to Hot/Cold/Sweets
Mouth Sores/Growths/Ulcers
Dry Mouth

CONSENT

The above information is accurate and complete to the best of my knowledge. The undersigned hereby authorizes the Doctor to perform all the necessary procedures deemed appropriate for my dental needs.

Patient Signature (Guardian, if Minor): ____

Print Name: ____ Date: __________________________