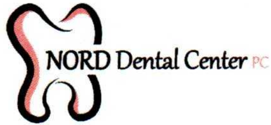


New Patient Registration

Today's Date ____________________

Patient Information (CONFIDENTIAL)

Name ______________________________________ Preferred Name ____________________________

Birthdate __________________ SS#_______________________

Address ______________________________ City _______________ State____ Zip code ___________

Cell Phone __________________ Home Phone __________________ Work Phone __________________

Email ____________________________________

Emergency contact/Phone Number ____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Other

Whom may we thank for referring you? ______________________________________

Responsible Party

Name of Person Responsible for this Account____________________________________

Contact Phone Number________________________ Relationship to Patient_______________________

Is the person responsible currently a patient in our office ☐ Yes ☐ No

Dental Insurance Information

Name of Insured ____________________________ Name of Employer ___________________________

Birthdate of Insured _________________ Relationship to Patient ______________________

Insurance Company___________________________ Group# _______________ ID#__________________

Insurance Co. Phone Number _____________________________

DO YOU HAVE ADDITIONAL DENTAL INSURANCE ☐ Yes ☐ No If yes, complete the following

Name of Insured ____________________________ Name of Employer ____________________________

Birthdate of Insured _________________ Relationship to Patient ______________________

Insurance Company ____________________________ Group# ________________ ID# _________________

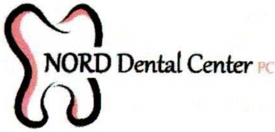
Insurance Co. Phone Number _____________________________

I acknowledge that all money is due the day of service. If I have dental insurance then only my portion will be due at the time of service. I understand that payment plans are not offered, however Care Credit is available (apply within). I authorize and request my insurance company to pay directly to the dentist otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents and that any unpaid balance after insurance will be subject to collections.

____

Signature of patient (or parent/guardian if minor)

Patient's Name: ____________________________



Medical History Form

As required by law, our office adheres to written policies and procedures to protect the privacy of the information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable law. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

MEDICAL HISTORY

Primary Physician's Name	Address	Zip code	Phone Number
			(____)__________

Has there been any change in your general health within the past year?........ Yes/No

When was your last visit to a physician?______________________ N/A ☐

What was the reason for the visit? ______________________

Are you currently under the care of a medical physician for any reason other than regular physicals?........ Yes/No

If so, what is the condition being treated? ______________________

Have you had a serious illness, injury or been hospitalized in the past 5 years? .... Yes/No

If yes, what was being treated? ______________________

Do you have any physical limitations?........ Yes/No

Describe ______________________

Please list any medications(s) you are currently taking as well as non-prescription medicine:

____

____

Has a physician or other dentist recommended that you take antibiotics prior to your dental treatment?........ Yes/No
(Please see section below for possible reasons)

If yes, Name of physician: ______________________ Phone: ______________

Recommended antibiotic and dosage: ______________________

Yes	No	
☐	☐	Have you had an **orthopedic total joint (hip, knee, shoulder, elbow, finger) replacement?** If yes, date of surgery: ______________ Did you have any complications? ______________
☐	☐	**Artificial (prosthetic) heart valve**
☐	☐	**Previous infective endocarditis**
☐	☐	Damaged valves in transplanted heart
☐	☐	Congenital heart disease
☐	☐	Unrepaired, cyanotic CHD
☐	☐	Repaired CHD (completely) in last 6 months
☐	☐	Repaired CHD with residual defects

☐ ☐ Do you use tobacco (smoking, snuff, chew)?
If so, how interested are you in stopping?
Circle one: VERY/ SOMEWHAT/ NOT INTERESTED

☐ ☐ Do you use use controlled substances?

☐ ☐ Do you drink alcoholic beverages?
If yes, how much do you typically drink in a week? __________

Yes	No	
☐	☐	Do you Snore?
☐	☐	Do you feel fatigued during the day?
☐	☐	Do you wake up feeling like you haven't slept?
☐	☐	Have you been told you stop breathing at night?
☐	☐	Do you gasp for air or choke while sleeping?