NEW PATIENT HEALTH AND REGISTRATION FORM

Patient Name: Last: _____ First: _____Middle: ___Title:____ Nick Name:_____
Home Address: _____
City: _____ State: _____Zip Code _____
Sex M F Date of Birth : _____Social Security Number:_____
Marital Status: _____ Email : _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____
Whom may we thank for referring you to our Practice? _____

DENTAL BENEFIT INFORMATION

Dental Benefit Company:_____ Subscriber's Name : _____
Subscriber's Social Security Number: _____ Date of Birth: _____Phone: _____
Group# _____Subscriber's Employer: _____

IF YOU HAVE TWO DENTAL BENEFITS PLEASE FILL OUT THE NEXT FEW LINES

Secondary Dental Benefit Company:_____ Subscriber's Name _____
Subscriber's Social Security Number: _____ Date of Birth: _____
Group # _____Subscriber's Employer: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

DENTAL HEALTH HISTORY INFORMATION

It is important that we know your medical and dental history. These facts have a direct bearing on your dental health. Thank you for taking the time to Completely fill out this Medical Form.

Reason for today's visit _____
How long has it been since you have last seen a Dentist _____Last Dental Cleaning & Exam _____
Last Full Set Of Xrays (or) Panorex ? ____Name of Previous Dentist _____
City:_ _____ State: _____ Phone Number: _____
How would you rate your Present Dental Health? _____ Poor Fair Good Excellent

Do you wear Dentures? Yes No _____ Are you Unhappy with them ?___ YES NO

Would you like to know about Permanent Replacements _____ YES NO

Are you APPREHENSIVE about Dental Treatment _____ YES NO

Have you ever had any Periodontal Treatment _____ YES NO

Do your Gums Bleed or feel tender or Irritated _____ YES NO

Are you aware of Grinding or Clenching your teeth _____ YES NO

Do you frequently have Ear Aches or Neck Pain _____ YES NO

Have you ever worn Braces YES NO _____ If yes how long ago? _____

Do you get Constant Bad Breath, or a Bitter or Sour Taste _____ YES NO

Do you Floss? YES NO _____ If yes how often_____

Would you like your smile to Look Better or Different? _____ YES NO

Would you like Information on Teeth Whitening? _____ YES NO

OVER---------->

MEDICAL INFORMATION

Are you presently under a Physician's care? _____ **YES NO**

If yes please list Conditions _____

Have you ever had Botox or Derma Fillers? _____

Family Physician : _____ **Number:** _____

List all Medications that you are presently taking (including Birth Control,Vitamins or over the counter meds)

Are you (or might you be) pregnant YES NO **Do you smoke? YES NO**

Do you Presently have (or) have ever been Diagnosed with any of the following conditions (please circle all that apply)

Abnormal Bleeding	Congenital Heart Lesion	Heart Disease/Attack	Pace maker
Alcohol Abuse	Cosmetic Surgery	Heart Murmur	Pain in Jaw /Joints
Allergies /Hives	Diabetes	Hemophilia	Psychiatric Treatment
Anemia	Difficulty Breathing	Hepatitis A,B, C	Rheumatic Fever
Angina Pectoris	Drug Abuse	High Blood Pressure	Shingles
Arthritis	Emphysema	HIV /AIDS Tested	Sickle Cell Disease
Artificial Bones/Joints	Epilepsy /Seizures	Kidney Disease	Sinus Conditions
Artificial Heart Valve	Fainting Spells	Leukemia	Stroke
Asthma	Fever Blisters	Low Blood Pressure	Thyroid Problems
Cancer /Chemotherapy	Glaucoma	Mitral Valve Prolapse	Ulcers
Colitis	Hay Fever	Nervousness	Venereal Disease

Please list below any other Medical/ Dental Conditions that you may have

_____

_____

Are you allergic to (or) have had any Adverse Reactions to any of the following Medications (Please circle all that apply)

Aspirin Codeine Erythromycin Nitrous Oxide Penicillin Sulfa General Anesthesia

Are you aware of being allergic to any medications that are not listed above?
YES NO (if yes please list below)

Patient Signature: **Date:**

REVISED SEPT.4 , 2012