New Patient Registration Form

Patient Personal Information

Title		Nickname		Birth Date	Age
Last, First				Marital Status	Sex
Address				Home #	Work #
				Cell #	Drive Lic
City, State, Zip				Emergency Contact	Emergency Phone #
Email				Student	SSN
Health Care Guardian Name				School Name	
Health Care Guardian Phone #				Referral Type	

Person responsible/guarantor for financial obligations

Title		Nickname		Birth Date	Age
Last, First				Marital Status	Sex
Address				Home #	Work #
				Cell #	Drive Lic
City, State, Zip				SSN	
Email					

Do you have Primary Dental Insurance? __ Yes __ No				Do you have Secondary Dental Insurance? __ Yes __ No			
Group No/Name				Group No/Name			
Insurance Name				Insurance Name			
Phone #				Phone #			
Employer Name				Employer Name			
Subscriber Last, First				Subscriber Last, First			
Subscriber Address				Subscriber Address			
City, State, Zip				City, State, Zip			
Relationship to Patient		Birth Date		Relationship to Patient		Birth Date	
Subscriber ID				Subscriber ID			

Patient Medical Information

Allergic To:

- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Barbiturates / Sleeping Pills
- ☐ Y ☐ N Codeine
- ☐ Y ☐ N Erythromycin
- ☐ Y ☐ N Iodine
- ☐ Y ☐ N Latex Rubber
- ☐ Y ☐ N Local Anesthetics
- ☐ Y ☐ N Metals
- ☐ Y ☐ N Epinephrine
- ☐ Y ☐ N Penicillin
- ☐ Y ☐ N NSAIDS
- ☐ Y ☐ N Sulfa Drugs
- ☐ Y ☐ N Amoxicillin
- ☐ Y ☐ N Other

Check, if applicable

- ☐ Y ☐ N Abnormal Bleeding
- ☐ Y ☐ N Alcohol/Drug Abuse
- ☐ Y ☐ N Anemia
- ☐ Y ☐ N Anorexia/Bulimia
- ☐ Y ☐ N Arthritis
- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Autoimmune Disease
- ☐ Y ☐ N Bisphosphonates
- ☐ Y ☐ N Blood Clotting Problems
- ☐ Y ☐ N Blood Thinners
- ☐ Y ☐ N Cancer / Tumor or Growth
- ☐ Y ☐ N Cardiac Pacemaker
- ☐ Y ☐ N Cardiovascular Disease
- ☐ Y ☐ N Chemotherapy/Radiation
- ☐ Y ☐ N Congenital Heart Defect/Heart
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Emphysema
- ☐ Y ☐ N Fever Blisters/Herpes
- ☐ Y ☐ N Frequent Headaches
- ☐ Y ☐ N Frequently Dry Mouth / Sjogren
- ☐ Y ☐ N Gag Reflex
- ☐ Y ☐ N Gall Bladder Trouble
- ☐ Y ☐ N Hay Fever
- ☐ Y ☐ N Heart Attack/Stroke
- ☐ Y ☐ N Heart Murmur/Mitral Valve Prol
- ☐ Y ☐ N Heart Valve Replacement
- ☐ Y ☐ N Hepatitis
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N Hives
- ☐ Y ☐ N Joint Replacement
- ☐ Y ☐ N Leukemia
- ☐ Y ☐ N Liver Disease
- ☐ Y ☐ N Pregnant
- ☐ Y ☐ N Premedicate
- ☐ Y ☐ N Rheumatic Heart Disease
- ☐ Y ☐ N Rheumatoid Arthritis
- ☐ Y ☐ N Seizures
- ☐ Y ☐ N Sexually Transmitted Disease
- ☐ Y ☐ N Shortness of Breath
- ☐ Y ☐ N Sinus Trouble
- ☐ Y ☐ N Stomach Ulcers
- ☐ Y ☐ N Thyroid Problems
- ☐ Y ☐ N Tuberculosis

Other

- ☐ Y ☐ N See Medical Questionnaire
- ☐ Y ☐ N See Scanned Documents
- ☐ Y ☐ N Pre-Med

☐ Y ☐ N AIDS/HIV Infection

☐ Y ☐ N Epilepsy

☐ Y ☐ N Fainting Spells

☐ Y ☐ N Lupus

☐ Y ☐ N Mental Health Problems

☐ Y ☐ N Pacemaker

Additional Comments

Dental Questionnaire

Dental Questionnaire (Please Check Box if "Yes")

Name of previous Dentist	_____
Date of your last cleaning	_____
Date of your last full series x-rays	_____
Last exam date	_____
Date of last cavity detection (bitewing) x-rays	_____
Do your gums bleed while brushing or flossing ?	☐
Are your teeth sensitive to hot, cold or sweets ?	☐
Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth ?	☐
Have you ever had burning of the tongue or cracking of the corners of your mouth ?	☐
Do you chew/smoke tobacco in any form ?	☐
Have you had any head, neck or jaw injuries ?	☐
Do you notice popping, clicking or soreness of the jaws or points just in front of the ears ?	☐
Do you clench or grind your teeth ?	☐
Have you ever had orthodontic treatment ?	☐
If Yes, date of placement	_____
Do you wear dentures or partials ?	☐
If Yes, date of placement of dentures ?	_____
Are you happy with your dentures ?	☐
Are you having any specific problems with your teeth, gums, or mouth at this time ?	☐
Are you happy with your smile ?	☐
Do you have problems with teeth/fillings breaking ?	☐
Do you regularly use dental floss ?	☐
Do you have, or have you ever been told, that you have Pyorrhea (Periodontal Disease) ?	☐
Do you have difficulty in opening your mouth widely ?	☐
Do you have an unpleasant taste or odor in your teeth/mouth ?	☐
Does food catch between your teeth ?	☐
Do you want to learn to control your dental disease and retain your teeth ?	☐

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list _____

Medical Questionnaire

Emergency contact phone _____

Emergency contact relationship to patient _____

Medical Questionnaire (Please Check Box if "Yes")

Family Physician _____

Phone _____

Are you currently under care of a Physician ? ☐

If Yes, what is the condition being treated ? _____

Have you had any serious illness, operation or been hospitalized within the past 5 years ? ☐

If Yes, what illness or problem ? _____

List of current Medications _____

Bone Disease _____

Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast) ☐

Have you ever taken the diet control drug Fen-Phen ? ☐

Do you use alcoholic beverages ? ☐

Do you smoke ? ☐

Women Only (Please Check Box if "Yes")

Are you pregnant? ☐

If Yes, what is your due date ? _____

Are you currently nursing ? ☐

Are you on hormone replacement therapy ? ☐

Are you on birth control pills / fertility drugs ? ☐

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list _____

Pediatric Medical History (Please check box for "YES" if applicable)

Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions ☐

Problems with physical growth or development ☐

Sinusitis, chronic adenoid/tonsil infections ☐

Sleep apnea/snoring, mouth breathing, or excessive gagging ☐

Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease ☐

Irregular heart beat or high blood pressure	☐
Asthma, reactive airway disease, wheezing, or breathing problems	☐
Cystic fibrosis	☐
Frequent exposure to tobacco smoke	☐
Jaundice, hepatitis, or liver problems	☐
Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems	☐
Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions	☐
Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder	☐
Bladder or kidney problems	☐
Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems	☐
Rash/hives, eczema or skin problems	☐
Impaired vision, hearing, or speech	☐
Developmental disorders, learning problems/delays, or intellectual disability	☐
Cerebral Palsy, brain injury, epilepsy, or convulsions/seizures	☐
Autism/autism spectrum disorder	☐
Recurrent or frequent headaches/migraines, fainting, or dizziness	☐
Attention deficit/hyperactivity disorder (ADD/ADHD)	☐
Behavioral, emotional, communication, or psychiatric problems/treatment	☐
Diabetes, hyperglycemia, or hypoglycemia	
Thyroid or pituitary problems	☐
Anemia, sickle cell disease/trait, or blood disorder	☐
Hemophilia, bruising easily, or excessive bleeding	☐
Transfusions or receiving blood products	☐
Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant	☐
Mononucleosis, Tuberculosis (TB), Scarlet Fever, or Cytomegalovirus (CMV)	☐
Methicillin resistant staphylococcus aureus (MRSA) or human immunodeficiency virus (HIV)/AIDS	☐
Please provide details for questions answered "YES"	_____
Additional Comments	
Any other significant medical history pertaining to this child or his/her family?	_____

By signing below, I certify that all of the above information is true to the best of my knowledge.

_____ _____

Patient/Guardian Signature **Date**

_____ _____

Dentist Signature **Date**