WELCOME TO OUR OFFICE

NEW PATIENT REGISTRATION FORM:

PATIENT'S NAME _____ BIRTHDAY _____/_____/_____ AGE_____

ADDRESS_____HOME PHONE_____

CITY_____ STATE_____ ZIP_____CELL PHONE_____

EMPLOYER/OCCUPATION_____WORK PHONE_____

DENTAL INSURANCE PLAN (if any)_____

And *WHOM MAY WE THANK FOR THIS REFERAL?*_____ ***We would like to say thanks!***

DENTAL HISTORY

FORMER DENTIST_____ DATE OF LAST EXAM_____

WHAT CONCERNS YOU ABOUT YOUR TEETH?_____

RATE YOURSELF ABOUT DENTAL VISITS: _____ Calm _____ A bit nervous _____ Very nervous

DENTAL HISTORY: _____Periodontal Treatment _____Orthodontic Treatment _____Frequency Brushing _____Flossing

MEDICAL HISTORY

PHYSICIAN'S NAME_____ PHONE_____ DATE OF LAST VISIT_____

ARE YOU PRESENTLY UNDER A PHYSICIAN'S CARE? _____Yes _____No

If YES, please explain _____

HAVE YOU EVER HAD A SERIOUS ILLNESS/ OPERATION, OR STILL HAVE ONE? _____Yes _____No

If YES, please explain _____

ARE YOU TAKING ANY MEDICATIONS OR SUPPLEMENTS? _____Yes _____No

If YES, please list _____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS OR DRUGS? _____Yes _____No If YES, list: _____

HAVE YOU EVER TAKEN BONE DRUGS? (Fosamax, Evista, Actonel, Boniva, Reclast, others) _____Yes _____No

CHECK ANY THAT APPLY: _____Allergies to Anesthetics _____Artificial Joints _____Artificial Heart Valve _____Hepatitis

_____High Blood Pressure _____Cancer _____Heart Problems _____Liver or Kidney Problems _____Tobacco Use ____Tuberculosis

_____Immune Problems _____Bleeding Problems ____HIV Positive ____Taking Contraceptives ____Latex Allergy _____Diabetes

____Now Pregnant _____ Psychiatric or Emotional Problems ____Other, please explain_____

Thank you for choosing our office for your dental care!

I CERTIFY THAT THE ABOVE IS COMPLETE & ACCURATE:

Signature_____ Date_____/_____/_____