New Patient Registration

PATIENT INFORMATION

Date: _____

Patient Legal Name (Last, First, M.I.):

_____

Nickname/Preferred Name: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

Sex: ☐ M ☐ F Age: _____ Birthdate: _____

SS#: _____

☐ Married ☐ Single ☐ Divorced ☐ Widowed

Patient Employer: _____

Occupation: _____

Employer Address: _____

_____

Employer Phone: _____

Spouse Information

Name (Last, First, M.I.): _____

Birthdate: _____ SS# _____

Spouse's Employer: _____

Occupation: _____

Whom may we thank for referring you?:

_____

DENTAL INSURANCE

Who is responsible for this account?: _____

Relationship to Patient: _____

Primary Insurance

Insurance Company: _____

Group #: _____

Subscriber ID#: _____

Subscriber Name (Last, First, M.I.):

_____

Relationship to Patient: _____

Birthdate: _____ SS#: _____

Secondary Insurance

Insurance Company: _____

Group #: _____

Subscriber ID#: _____

Subscriber Name (Last, First, M.I.):

_____

Relationship to Patient: _____

Birthdate: _____ SS#: _____

CONTACT INFORMATION

Home Ph: _____ Cell Ph: _____ Work Ph: _____ (Ext: _____)

Spouse's cell: _____ E-mail: _____

Best time and place to reach you: _____

We now offer text & e-mail messaging confirmation; would you like to receive texts/e-mails to remind you of your appointments?

☐ YES ☐ NO If YES, please list the cell phone number/e-mail you wish to receive reminders on: _____

In case of an emergency, contact (specify someone who does not live in your household.)

Name: _____ Relationship to patient: _____

Home Ph: _____ Cell Ph: _____ Work Ph: _____ (Ext: _____)

Please complete both sides

DENTAL HISTORY

Patient Name_____

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist_____ Date of most recent treatment (other than a cleaning)_____/_____/_____

Date of most recent dental exam _____/_____/_____ Date of most recent x-rays_____/_____/_____

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? _____

How often do you brush your teeth?_____ How often do you floss your teeth? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [_____]	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐	☐
6. Have you had any teeth removed?	☐	☐
SMILE CHARACTERISTICS		
7. Is there anything about the appearance of your teeth that you would like to change?	☐	☐
8. Have you ever whitening (bleached) your teeth?	☐	☐
9. Have you felt uncomfortable or self-conscious about the appearance of your teeth?	☐	☐
10. Have you been disappointed with the appearance of previous dental work?	☐	☐
BITE AND JAW JOINT		
11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
12. Do you/would you have any problems chewing gum?	☐	☐
13. Do you/would you have any problems chewing bagels, baguettes, protein bars, or other hard foods?	☐	☐
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐	☐
15. Are your teeth crowding or developing spaces?	☐	☐
16. Do you have more than one bite and squeeze to make your teeth fit together?	☐	☐
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
18. Do you clench or grind your teeth in the daytime or make themsore?	☐	☐
19. Do you have any problems with sleep or wake up with an awareness of your teeth?	☐	☐
20. Do you wear or have your ever worn a bite appliance?	☐	☐
TOOTH STRUCTURE		
21. Have you had any cavities within the past 3 years?	☐	☐
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? (DRYMOUTH)	☐	☐
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?	☐	☐
25. Do you have grooves or notches on your teeth near the gumline?	☐	☐
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
27. Do you get food caught between any teeth?	☐	☐
GUM AND BONE		
28. Do your gums bleed when brushing or flossing?	☐	☐
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
30. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
31. Is there anyone with a history of periodontal disease in your family?	☐	☐
32. Have you ever experienced gum recession?	☐	☐
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
34. Have you experience a burning sensation in your mouth? (Tongue or lips)	☐	☐
35. Do you ever have blisters/cold sores/canker sores in your mouth/lips?	☐	☐
36. Do you ever experience lip or cheek biting?	☐	☐

MEDICAL HISTORY

Patient Name_____ Preferred Name_____ Age_____

Name of Physician & their specialty_____

Date of last physical examination_____ Purpose_____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. Hospitalization for illness or injury	☐	☐
2. An allergic reaction to:		
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin ☐ erythromycin		
☐ tetracycline ☐ **LATEX**		
☐ local anesthetic ☐ **FLUORIDE**		
☐ sulfa ☐ metals (nickel, gold, silver,_____)		
☐ other_____		
3. Heart problems (i.e. cardiac surgery, heart murmur, mitral valve prolapse, heart defect, angina, etc)	☐	☐
4. Heart attack (date:_____)	☐	☐
5. History of infective endocarditis	☐	☐
6. Artificial heart valve, repaired heart defect (PFO)	☐	☐
7. Pacemaker or implanted heart defibrillator	☐	☐
8. Artificial joints/implants (type:_____date:_____)	☐	☐
If yes, do you need to be premedicated w/antibiotics?	☐	☐
9. Rheumatic or scarlet fever	☐	☐
10. High or low blood pressure	☐	☐
11. Stroke (date:_____)	☐	☐
12. Anemia or other blood disorder	☐	☐
13. Prolonged bleeding due to a slight cut (INR>3.5)	☐	☐
14. Respiratory problems (i.e. asthma, emphysema, bronchitis)	☐	☐
15. Tuberculosis	☐	☐
16. Sleep/breathing problems (i.e. snoring, sinus, sleep apnea)	☐	☐
17. Diabetes (HbA1c=_____)	☐	☐
18. Kidney disease	☐	☐
19. Liver disease	☐	☐
20. Jaundice	☐	☐
21. Thyroid, parathyroid disease, or calcium deficiency	☐	☐
22. Hormone deficiency	☐	☐
23. High cholesterol or taking statin drugs	☐	☐
24. Digestive disorders (i.e. gastric reflux, ulcer, etc)	☐	☐
25. Osteoporosis/osteopenia (i.e. taking bisphosphonates)	☐	☐
26. Arthritis	☐	☐
27. Glaucoma	☐	☐
28. Loss of hearing or vision	☐	☐

	YES	NO
29. Contact lenses	☐	☐
30. Head or neck injuries	☐	☐
31. Epilepsy, convulsions (seizures)	☐	☐
32. Neurologic problems	☐	☐
33. Cold sores/oral herpes/fever blisters/canker sores	☐	☐
34. Any lumps or swelling in the mouth	☐	☐
35. Hives, skin rash, hay fever	☐	☐
36. Venereal disease	☐	☐
37. Hepatitis (type_____)	☐	☐
38. HIV/AIDS	☐	☐
39. Tumor, abnormal growth	☐	☐
40. Cancer (type:_____year of diagnosis:_____)	☐	☐
41. Radiation therapy	☐	☐
42. Chemotherapy	☐	☐
43. Emotional problems	☐	☐
44. Psychiatric treatment	☐	☐
45. Alcohol/drug dependency	☐	☐
46. Parkinson's disease	☐	☐
47. Alzheimer's disease	☐	☐
ARE YOU:		
48. Presently being treated for any other illness/condition	☐	☐
If yes, please list:_____		
49. Aware of a change in your general health	☐	☐
50. Taking medication for weight management	☐	☐
51. Taking dietary supplements	☐	☐
52. Taking blood thinner medications	☐	☐
53. Often exhausted or fatigued	☐	☐
54. Subject to frequent headaches	☐	☐
55. A smoker/smoked previously/other tobacco use	☐	☐
56. Considered a touchy person	☐	☐
57. Often unhappy or depressed	☐	☐
58. FEMALE – taking birth control pills	☐	☐
59. FEMALE – pregnant or nursing (due date=_____)	☐	☐
60. MALE – Prostate disorders	☐	☐

- **Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?** ☐ ☐
- Describe any current medical treatment, impending surgery, or other treatment not mentioned above:

_____

List all medications, supplements, and/or vitamins currently being taken or any that have been taken within the last two years:

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

To the best of my knowledge, the preceding information is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes in my medical/dental history.

Patient's Signature_____ Date_____

(Update)_____ Date_____

(Update)_____ Date_____

(Update)_____ Date_____