# Patient Registration

## Patient Information

Today's Date: _____

Patient Name _____ Gender _____ Date of Birth: _____

Street address_____ City _____ State _____ Zip _____

Phone Number: (h) _____(c) _____ (w) _____

E-mail Address: _____ Social Security # _____

Spouse/Partner's Name_____ Phone _____

Emergency Contact: _____ Phone _____

Employer _____ Occupation _____

Whom May We Thank For Referring you?_____

## Financial Information

Name of Person Financially Responsible: _____

Relationship to the Patient _____ Employer _____

Responsible Party Social Security # _____ Responsible Party DOB: _____

Phone Number: (h) _____ (c) _____ (w) _____

## Insurance Information

**Primary Plan**

Name of Policyholder _____ Gender _____ DOB: _____

Insurance Company _____ Employer _____

Group # _____ Policy # _____ Policyholder ID or SS# _____

**Secondary Plan (if applicable)**

Name of Policyholder _____ Gender _____ DOB: _____

Insurance Company _____ Employer _____

Group # _____ Policy # _____ Policyholder ID or SS# _____

*Please present your Government Issued ID & Insurance Card(s) to our Administrative Team.*

## Medical History

Today's Date: _____

Patient Name: _____ Date of Birth: _____

| | Yes | No |
|---|---|---|
| 1. Do you currently have any health problems? If yes, please explain: _____ _____ | □ | □ |
| 2. Are you currently under the care of a physician? Name of PCP: _____ Phone Number: _____ | □ | □ |
| 3. Do you us tobacco products? | □ | □ |
| 4. If yes, how often _____ | | |
| 5. Are you taking any controlled substances? If yes, please explain _____ _____ | □ | □ |
| 6. Are you pregnant or think you may be? | □ | □ |
| 7. Are you breastfeeding? | □ | □ |
| 8. Have you been hospitalized for a serious illness or had major surgery in the past five years? If yes, please explain: _____ _____ | □ | □ |
| 9. Have you ever taken FOSAMAX, BONIVA, ACTONEL or ANY Osteoporosis or cancer medication containing bisphosphonates? Please explain _____ _____ | □ | □ |

10. Have you ever been told by your physician or or surgeon you should "premedicate" with antibiotics prior to a dental visit? □ Yes □ No Please explain: _____ _____
11. Have you ever had a "deep cleaning? _____
12. Have you ever been told that you have gingivitis bone loss, or gum disease? _____
13. Do you take anti-depressants? _____
14. Do you use sleep aids? _____
15. Do you have insomnia? _____
16. Have your parents or siblings lost teeth due to periodontal disease? _____

17. Please provide the names of medications you take: (include RX, OTC, Birth Control & Vitamins)

_____
_____
_____
_____
_____

18. **Are you allergic to or have you had any negative reaction to the following:**

□ Local Anesthetics □ Sulfa Drugs □ Aspirin □ Any Metals □ Barbiturates □ Penicillin / Antibiotics
□ Codeine □ Nitrous Oxide □ Latex □ Sedatives □ NSAIDS (ibuprofen, acetaminophen)

19. **Please list any additional allergies (including foods):** _____

20. **Do you, or have you had, any of the following health conditions or treatment?**

□ Acid Reflux/Heartburn
□ Alzheimer's Disease
□ Anemia
□ Angina Pectoris (chest pain)
□ Anxiety or Nervousness
□ Arthritis
□ Artificial Heart Valve
□ Artificial Joins (hip, knee, etc.)
□ Asthma: Inhaler? □ Yes □ No
□ Blood Transfusion: Mo/Yr? _____
□ Chemotherapy: Mo/Yr? _____
□ Congenital Heart Lesion
□ Cortisone Treatment: Mo/Yr _____
□ Cosmetic Surgery
□ Dementia or Memory Loss
□ Diabetes: Insulin Dependent? □ Yes □ No
□ Drug or Alcohol Addiction
□ Eating Disorder
□ Emphysema: O2 Dependent? □ Yes □ No
□ Epilepsy or Seizures
□ Fever Blisters or Mouth Sores
□ Glaucoma
□ Heart Disease/Attack: Mo/Yr _____
□ Heart Murmur
□ Heart Pacemaker
□ Heart Surgery: Mo/Yr _____
□ Hepatitis: □ A □ B □ C
□ High Blood Pressure
□ HIV or AIDs
□ Jaw Pain (TMJ)
□ Kidney Disease
□ Hemophilia (bleeding problem)
□ Liver Disease
□ Lupus
□ Migraines or Frequent Headaches
□ Mitral Valve Prolapse
□ Psychiatric Treatment
□ Radiation: Mo/Yr? _____
□ Rheumatic Fever
□ Seasonal Allergies
□ Sinus Trouble or Frequent Sinus Infections
□ Sjogren's Syndrome
□ Sleep Apnea
□ Stroke: Mo/Yr _____
□ Thyroid Disease
□ Tuberculosis (TB)
□ Ulcers
□ Venereal Disease

# Dental History

Today's Date: _____

Patient Name: _____ Date of Birth: _____

1. When was your last visit to a dentist? _____ What was done? _____
2. When was your last complete dental examination? _____ Full set of X-Rays? _____
3. How can we help you today? _____
4. On a scale of 1 -10, 10 being the most fearful, how much anxiety do you have about being at the dentist? _____
5. On a scale of 1-10 how rested do you feel in the morning? _____

| | Yes | No |
|---|---|---|
| 6. Are you having any problems with your teeth, gums, or mouth now? | □ | □ |
| 7. Do your gums feel irritated or bleed while brushing or flossing? | □ | □ |
| 8. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids? | □ | □ |
| 9. Do you have crowding or crooked teeth? | □ | □ |
| 10. Are you experiencing any pain or discomfort with your teeth? | □ | □ |
| 11. Do you have any sores or lumps in or around your mouth? | □ | □ |
| 12. Have you had any head, neck, or jaw injuries? | □ | □ |
| 13. Have you ever felt clicking, popping or pain in your jaw? | □ | □ |
| 14. Do you ever experience difficulty opening/closing your jaw or difficulty chewing? | □ | □ |
| 15. Do you have frequent headaches, earaches, or neck pains? | □ | □ |
| 16. Are you aware of clenching or grinding your teeth? | □ | □ |
| 17. Have you ever had any difficult extractions or extraction complications in the past? | □ | □ |
| 18. Have you ever had orthodontic treatment (braces)? | □ | □ |
| 19. Do you wear dentures or partial dentures? | □ | □ |
| 20. Do you floss regularly? | □ | □ |
| 21. Do you have discolored or stained teeth that bother you? | □ | □ |
| 22. Do you like your smile? | □ | □ |
| 23. Have you ever had a Oral Cancer Screening? | □ | □ |
| 24. Are you interested in Fluoride Treatments (for help with sensitivity and/or cavity prevention) | □ | □ |
| 25. Do you currently use a electric toothbrush? | □ | □ |

Do you have any other concerns about your health that you would like to discuss? _____

_____

_____

**Authorization and Release Statement:** The questions above have been answered correctly to the best of my knowledge. I understand that providing misinformation can be perilous to my health and may prevent my dental team from properly caring for me. I authorize New Day Dentistry PLLC and my dentist to release my information, including any diagnosis, treatment or payment records, to third party payers, and/or other healthcare practitioners. I authorize my insurance company to make payments directly to my dentist and New Day Dentistry PLLC. In the event of underpayment or denial by my insurance company, I agree to be responsible for the balance of any services or treatment provided to me. I further understand that New Day Dentistry PLLC assesses a fee of $50 per scheduled hour for missed or cancelled appointments when two business days notice is not given and agree to be responsible for these fees. My signature below indicates that I have read, understand and agree to the terms of this Statement.

_____ _____

Signature of Patient (or Parent/Guardian) Date