



New Patient Registration Form

I. GENERAL INFORMATION

First Name: _____ Middle: _____ Last Name: _____

Preferred Name (Nickname): _____ Date of Birth: _____

Gender: Male Female Other Preferred Pronouns: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Occupation: _____ Employer: _____

II. EMERGENCY INFORMATION

Emergency Contact: _____ Relationship: _____

Emergency Phone Number: _____

Family Doctor: _____ Doctor Phone Number: _____

III. DENTAL INFORMATION

Reason for today's visit: _____

Date of last dental visit: _____ Former Dentist: _____

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

Please select all that apply:

- | | | |
|--|---|--|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Food collection between teeth |
| <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Grinding/Clenching teeth |
| <input type="checkbox"/> Sensitivity (Cold/Hot) | <input type="checkbox"/> Clicking/Popping jaw | <input type="checkbox"/> Sores/Growths in mouth |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Broken fillings |
| <input type="checkbox"/> Sensitivity when biting | <input type="checkbox"/> Difficulty opening/closing jaw | |



IV. INSURANCE INFORMATION

Do you have dental insurance? Yes No

Primary Insurance Carrier: _____ Group #: _____

Policyholder/Subscriber Name: _____ Relationship to Patient: _____

Subscriber DOB: _____ Subscriber Employer: _____

Subscriber SSN/Member ID: _____

V. OTHER INFORMATION

Social Security Number: _____

How did you hear about our office?

Friend/Family Online Drive-by Other: _____

VI. MEDICAL AND HEALTH HISTORY

Preferred Pharmacy: _____ Phone: _____

Date of Last Physical Exam: _____

Are you currently pregnant? No Yes (Weeks: _____)

Allergies & Reactions

Please list all allergies (medications, latex, metals, seasonal) and the specific reaction.

1. _____ Reaction: _____

2. _____ Reaction: _____

Medications & Substances

Honest disclosure is critical to prevent adverse reactions with dental anesthetics.

- **Current Medications:** (List all prescriptions, OTC, and vitamins):

- **Do you use tobacco/nicotine?** No Yes (Type: _____ Freq: _____)

- **Do you consume alcohol?** No Yes (Freq: _____)

- **Do you use medical marijuana?** No Yes ([Medical Card Holder](#): Yes No)

- **Do you use recreational drugs?** No Yes (Specify: _____)



Health Conditions

Please check if you have or have ever had any of the following:

Cardiovascular

- High Blood Pressure Heart Attack / Stroke Heart Murmur / Arrhythmia
- Artificial Heart Valve Pacemaker / Defibrillator Chest Pain (Angina)

Respiratory & Systemic

- Tuberculosis COPD / Emphysema Sleep Apnea / Snoring
- Kidney Disease Liver Disease / Hepatitis Asthma / Respiratory Issues

Neurological & Mental

- Fainting / Dizziness Epilepsy / Seizures Anxiety / Depression
- Bipolar Disorder ADHD / ADD Parkinson's / MS

Blood & Immune

- Radiation Treatment Cancer / Chemotherapy HIV / AIDS
- Hemophilia / Easy Bleeding Anemia / Leukemia

Endocrine & Other

- Glaucoma Sinus Trouble Thyroid Problems
- Stomach Ulcers Diabetes (Type: ____, A1C____)

Musculoskeletal

- Lupus Fibromyalgia Osteoporosis
- Artificial Joint(s) Arthritis / Rheumatism

Do you have any other disease or problem not listed? _____
