NEW PATIENT REGISTRATION FORM

Patient Information:

Patient Name: _____ Preferred Name: _____

Birth Date: _____ Male: _____ Female: _____ Married: _____ Single: _____ Minor: ☐Yes ☐No

SS#: _____ Driver's License #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work #: _____ Cell #: _____

E-mail address: _____ Best way to reach you:_____

Employer:_____

Emergency Contact: _____ Phone #: _____

Other family members seen by us: _____

How did you hear of us? _____

If referred by someone, whom may we thank for the referral? _____

Parent/Guardian Information (if patient is a minor):

Name: _____ Relationship to patient: _____

Birth Date: _____ SS#: _____ Driver's License #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work #: _____ Cell #: _____

Spouse Information

His/ Her Name: _____Birthdate: __/__/__ Social Security #: _____

Employer: _____ Work Phone #: (___) _____ Ext: ___ Driver License #: _____

Dental Insurance Information (Primary):

Dental Coverage? ☐Yes ☐ No Medical Coverage? ☐Yes ☐No Orthodontic Coverage? ☐ Yes ☐No

Policyholder's Name: _____ Birth Date: _____ SS#: _____

Insurance Company: _____ Group #: _____

Employer: _____ Policyholder's ID#: _____

Patient Relationship to Policyholder: Self _____ Spouse _____ Child _____ Other _____

Dental Insurance Information (Secondary):

Dental Coverage? ☐Yes ☐ No Medical Coverage? ☐Yes ☐No Orthodontic Coverage? ☐ Yes ☐No

Policyholder's Name: _____ Birth Date: _____ SS#: _____

Insurance Company: _____ Group #: _____

Employer: _____ Policyholder's ID#: _____

Patient Relationship to Policyholder: Self _____ Spouse _____ Child _____Other _____

Dental History

Why have you come to the dentist today? _____

Are you currently in pain? ☐Yes ☐No

Do you require antibiotics before dental treatment? ☐Yes ☐No

Have you experience problems associated with any previous dental work? ☐Yes ☐No

Do you now or have you ever experience pain/ discomfort in your jaw joint (TMJ/ TMD)? ☐Yes ☐No

Your current dental health is: ☐Good ☐Fair ☐Poor

Do you floss daily? ☐Yes ☐No

Do you brush daily? ☐Yes ☐No

Do you use anything in addition to your brush and floss? ☐Yes ☐No

If yes, what? _____

Do you gums ever bleed? ☐Yes ☐No

Do your gums ever itch? ☐Yes ☐No

Have you ever had periodontal disease? ☐Yes ☐No

Do you have mobility in your teeth? ☐Yes ☐No

Are your teeth sensitive to heat, cold or anything else? ☐Yes ☐No

Do you still have wisdom teeth? ☐Yes ☐No

Do you experience dry mouth? ☐Yes ☐No

Do you have a previous or present dentist? ☐Yes ☐No

If yes, what was their name? _____ Date of Last Visit? _____

Are you happy with the way your smile looks? ☐Yes ☐No

If no, what would you change? _____

Do you have a personal physician? ☐Yes ☐No Physicians Name: _____ Date of last visit: _____

Address: _____ Phone # _____

Your current physical health is: ☐Good ☐Fair ☐Poor

Do you smoke or use tobacco or marijuana in any form (including electric cigarettes, pens, or vaporizers)? ☐Yes ☐No

Do you snore, hold your breath while sleeping or use a CPAP? ☐Yes ☐No

Have you taken Fosamax or any other bisphosphate? ☐Yes ☐No

Are you allergic to any of the following?

☐ Aspirin	☐ Erythromycin	☐ Sedatives
☐ Barbiturates	☐ Jewelry/Metals	☐ Sulfa Drugs
☐ Codeine	☐ Latex	☐ Tetracycline
☐ Dental anesthetics	☐ Penicillin	☐ Other

For Women:

Are you or could you be pregnant? ☐Yes ☐No

Are you nursing? ☐Yes ☐No

Taking Oral Contraceptives? ☐Yes ☐No

Are you currently taking any of the following? Please check all that apply.

- ☐ Acetaminophen
- ☐ Antibiotics
- ☐ Antihistamines
- ☐ Aspirin
- ☐ Blood Thinners
- ☐ Blood Pressure Medication
- ☐ Cold Remedies
- ☐ Heart Medication
- ☐ Insulin/ Diabetes Drugs
- ☐ Nitroglycerin
- ☐ Recreational Drugs
- ☐ Steroids/ Cortisone
- ☐ Thyroid Medication
- ☐ Tranquilizers

Do you or have you experienced the following? Please check those that apply:

- ☐ Abnormal Bleeding/ Extended Clotting Time
- ☐ Alcohol Abuse
- ☐ Alzheimer's/ Dementia
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Artificial Valves
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chicken Pox
- ☐ COPD
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Depression
- ☐ Diabetes Type I or II
- ☐ Difficulty Breathing
- ☐ Drug Abuse
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Fever Blisters
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Headaches
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV+ / AIDS
- ☐ Hospitalized for Any Reason
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Pacemaker
- ☐ Persistent Cough
- ☐ Psychiatric Treatment
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Steroid Therapy
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Sexual Transmitted Diseases

Are you experiencing any disease, condition or problem not listed here? Please explain below:

_____

_____

_____

Authorization

I affirm that the information is have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment is _____

_____

Signature Date

I certify that I am covered by _____ Insurance Co. and I assign directly to Dr. Softley all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and am responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure payment of benefits. I authorize the use of this signature in all my insurance submissions, whether manual or electronic.

_____

Signature Date