New Patient Registration

Patient's Name ______________________ Preferred Name ______________________

Sex: ❑ M ❑ F Date of birth ___/___/___ SSN ______________________

Please check one: ❑ Single ❑ Married ❑ Separated ❑ Widow

Home Address ______________________ City ____________ State ______ Zip ______

Email Address ______________________

Home phone # ______________________ Work Phone # ______________________

Cell Phone # ______________________

Person Responsible for Account ❑ Same as Above ______________________

Date of Birth ___/___/___ Email address ______________________ Phone ____________

How did you hear about our office? ❑ From another patient

Name of Person or Office Referring you to our practice? ______________________

❑ Dental Office ❑ Newspaper/Magazine ❑ TV/Radio ❑ Billboard ❑ School ❑ Work ❑ Insurance

❑ Other ____________

Emergency Information

Name of person to contact in the event of an emergency ______________________

Phone # ______________________

DENTAL INSURANCE INFORMATION (Primary Carrier)	If you have secondary insurance coverage, complete this for the second coverage
Insured's Name ______________________	Insured's Name ______________________
DOB ____________ MEMBER ID ____________	DOB ____________ MEMBER ID ____________
Insured's Employer ______________________	Insured's Employer ______________________
Insurance Company ______________________	Insurance Company ______________________
Phone # ______________________	Phone # ______________________
Group # ______________________	Group # ______________________

Gentle Dentist

Patient's Name: ______________________________

Dental History

Please check any of the following that apply to you:

- ❑ Sensitivity (hot, cold, sweets, pressure)
- ❑ Headaches, ear aches, neck pain
- ❑ Jaw joint pain
- ❑ Teeth or fillings breaking
- ❑ Grinding or clenching teeth
- ❑ Bleeding, swollen or irritated gums
- ❑ Loose, chipped tooth/teeth
- ❑ Bad breath or bad taste in your mouth

What would you like to do to improve your smile?

- ❑ Whiten
- ❑ Straighten / Close spaces
- ❑ Replace silver fillings
- ❑ Repair chipped teeth
- ❑ Replace missing teeth
- ❑ Replace old crowns

Do you have or have you ever had any of the following?

- ❑ Dentures
- ❑ Partial Dentures
- ❑ Braces
- ❑ Periodontal (gum) treatments

____
Name of previous dentist

____
City & State

____
Phone number

What is the most important thing about your visit today?

____

Medical History

- ❑ Heart disease/murmur
- ❑ Liver/Hepatitis
- ❑ Kidney disease
- ❑ Diabetes
- ❑ Speech/hearing problems
- ❑ Cerebral palsy
- ❑ Cancer/tumor/growths
- ❑ Bleeding/transfusions/blood disorders
- ❑ Anemia
- ❑ Seizures/Epilepsy
- ❑ Head/neck/back injuries
- ❑ Breathing problems/lung disease
- ❑ Anxiety/Depression
- ❑ HIV/AIDS
- ❑ High Blood Pressure
- ❑ Hospitalizations/surgeries/illnesses
- ❑ Pre-medicated
- ❑ Fainting/dizziness
- ❑ Artificial joints
- ❑ Tobacco user (currently)
- ❑ Glaucoma/eye problems
- ❑ Alcohol user (currently)
- ❑ Pregnancy (due date __/__/__)
- ❑ Radiation treatment/chemotherapy
- ❑ Arthritis/Rheumatism
- ❑ Sinus problems/hayfever
- ❑ Stroke/CNS/TIA

- ❑ Complication after dental treatment
- ❑ Pacemaker follow-up
- ❑ Stomach problems/ulcers/GI disease
- ❑ Osteoporosis
- ❑ Thyroid disease
- ❑ Organ transplant
- ❑ Marijuana or other street drugs
- ❑ Problems with Anesthesia
- ❑ On blood thinners
- ❑ Use C-Pap Machine at night

Are you taking any osteoporosis medications?
❑ Yes ❑ No
If yes, please list medications:

____
____

Do you have any allergies?
❑ No ❑ Yes ❑ Medications ❑ Latex
If yes, please list all allergies:

____
____
____
____

Please list any medications that you take or provide a list:

❑ I am currently NOT taking any medications.

____
____
____
____
____
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____
____
____
____

Patient, Parent (or Guardian) signature: ______________________________ Date: __________

Doctor signature: ______________________________ Date: __________