New Patient Registration

(ALL INFORMATION VOLUNTEERED ON THIS FORM IS FOR DOCTOR'S USE ONLY AND WILL NOT BE SHARED WITH ANYONE WITHOUT YOUR CONSENT)

Patient First Name:	Middle:	Last:
Street Address:		
City:	State:	Zip
Social Security #:	Email Address:	

Home Phone:	Cell Phone:

Date of Birth:	Age:	Sex:	Height:	Weight:

Has the patient had anything to eat or drink in the past 5 hours? ☐Yes ☐No
If yes, please explain: ______________________________

Has the patient been treated at a hospital within the past 5 years? ☐Yes ☐No
If yes, please explain: ______________________________

Is the patient presently under a physician's care? ☐Yes ☐No
If yes, please explain: ______________________________

Please list any medications the patient is taking: ______________________________

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Has the patient used any of the following during their life? ☐Yes ☐No
If yes, please circle drugs used: Marijuana Heroin Crack Meth any other illegal drug

Is the patient allergic to any of the following? Please ☑ any that apply:

☐ Novocain ☐ Pentothal ☐ Penicillin ☐ Sulfa Drugs ☐ Aspirin ☐ Phenergan
☐ Codeine ☐ Lortab ☐ Demerol ☐ Percocet ☐ Latex

List any other drug allergies the patient has: ______________________________

Has the patient suffered from or experienced any of the following? Please ☑ any that apply:

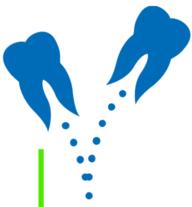
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Cancer
☐ Chest Pain
☐ Chronic Cough
☐ Diabetes
☐ Emphysema
☐ Excessive Bleeding
☐ Glaucoma
☐ Heart Defect
☐ Heart Disease
☐ Heart Murmur
☐ HIV / AIDS
☐ Hemophilia
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Nephritis
☐ Rheumatic Fever
☐ Seizures
☐ Sinus Difficulty
☐ Sleep Apnea/Snoring
☐ Stroke
☐ Tuberculosis

Has the patient had a recent cold? ☐Yes ☐No

Is the patient pregnant (Women only)? ☐Yes ☐No

Does the patient smoke? ☐Yes ☐No
If yes, how many cigarettes per day? __________

(CONTINUED ON BACK)



Name of Patient's Dentist:	Office Located in What City:
Name of Patient's Physician:	Office Located in What City:

Do you have braces? ☐Yes ☐No
If yes, Who is your Orthodontist: ______________________

How did you hear about us? Please ☑ any that apply:

☐ Valpak ☐ Money Mailer ☐ Billboard ☐ Friend / Family
☐ Internet ☐ Radio ☐ TV
☐ Dr. Referral (if checked, Doctor's name): ______________________
☐ Other: ______________________

THE FOLLOWING SHOULD BE FILLED OUT BY THE INDIVIDUAL RESPONSIBLE FOR ACCOMPANYING THE PATIENT HOME TODAY

First Name:		Last:
Street Address:		
City:	State:	Zip
Home Phone:		Cell Phone:
Age:	Relation to Patient:	

I confirm that all above information is a complete, accurate and honest representation of the patient's information and health history.

Patient or Guardian Name:	Date:
Signature:	

FOR OFFICE USE ONLY:

☐ Highlights ☐ Insurance / Medicaid ☐ Consent
☐ Referral ☐ Dr. Letter ☐ Insurance info verified