NEW TOWN DENTAL

Patient Registration Form

PATIENT INFORMATION

First Name		Middle Initial		Last Name			
Nickname		Gender	☐ Male ☐ Female	Birth Date		Age	
Social Security #		Driver's License #		E-mail			
Address		City		State		ZIP Code	
Home Phone		Cell Phone					
Marital Status	☐ Married	☐ Divorced	☐ Legally Separated	☐ Widow	☐ Single		
Employer		Occupation		Business Telephone			

WHO CAN WE THANK FOR REFERRING YOU TO OUR PRACTICE?

☐ Current Patient ☐ Referring Doctor ☐ Internet ☐ Insurance ☐ Other: _____

Referral Name	

RESPONSIBLE PARTY (if self is selected, please skip to the next section)

☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other: _____

First Name		Last Name		Social Security #			
Birth Date		Age		Telephone			
Address		City		State		ZIP Code	
Employer		Business Telephone					

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE COMPANY						SECONDARY DENTAL INSURANCE COMPANY					
Primary Policy Holder	First Last					Primary Policy Holder	First Last				
Relation		Gender	☐ Male ☐ Female			Relation		Gender	☐ Male ☐ Female		
S.S. #		Birth Date				S.S. #		Birth Date			
Address						Address					
City		State		ZIP Code		City		State		ZIP Code	
Telephone						Telephone					
Primary Policy Holder Employer						Primary Policy Holder Employer					
Business Address						Business Address					
City		State		ZIP Code		City		State		ZIP Code	
Business Telephone						Business Telephone					
Insurance Co. Name						Insurance Co. Name					
Address						Address					
City		State		ZIP Code		City		State		ZIP Code	
Telephone						Telephone					
Policy I.D. #						Policy I.D. #					
Group #		Plan Name				Group #		Plan Name			

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HEALTH HISTORY

Height		**Weight**	

Are you under the care of a physician? If yes, please complete the line below.					☐ Yes ☐ No
Date of Last Visit		**Physician Name**		**Physician Phone**	
Preferred Pharmacy		**Pharmacy Location**		**Pharmacy Phone**	
Have you had any recent surgeries?					☐ Yes ☐ No
If yes, please describe					

FOR WOMEN ONLY

Are you pregnant?	☐ Yes ☐ No	**If yes, number of weeks**	
Are you nursing?	☐ Yes ☐ No	**Are you taking birth control pills?**	☐ Yes ☐ No

WARNING: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician for assistance regarding additional methods of birth control.

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

	Yes	No		Yes	No		Yes	No
Abnormal Bleeding			**Frequent Headaches**			**Osteoporosis**		
Allergies			**Glaucoma**			**Pacemaker**		
Alcohol Abuse			**Hay Fever**			**Pneumocystis**		
Anemia			**Heart Attack**			**Psychiatric Problems**		
Angina Pectoris			**Heart Disease**			**Radiation Therapy**		
Arthritis			**Heart Murmur**			**Respiratory Problems**		
Artificial Heart			**Heart Surgery**			**Rheumatic Fever**		
Artificial Bones			**Hemophilia**			**Rheumatism**		
Asthma			**Hepatitis A**			**Seizures**		
Blood Disease			**Hepatitis B**			**Shingles**		
Blood Transfusion			**Hepatitis C**			**Sickle Cell Disease**		
Cancer - Chemotherapy			**High Blood Pressure**			**Sinus Problems**		
Colitis			**HIV + / AIDS**			**Sleep Apnea**		
Congenital Heart			**Irregular Heart Beat**			**Stomach/Intestinal Problems**		
Cosmetic Surgery			**Jaundice**			**Stroke**		
Diabetes			**Jaw Joint Pain**			**Thyroid Problems**		
Difficulty Breathing			**Joint Replacements**			**Tuberculosis**		
Drug Abuse			**Kidney Disease**			**Tumors/Growths**		
Emphysema			**Liver Disease**			**Ulcers**		
Epilepsy			**Low Blood Pressure**			**Venereal Disease**		
Fainting Spells			**Mitral Valve Prolapse**			**Yellow Jaundice**		
Fever Blisters								

Is there any disease, condition, or problem that you think our office should know about that is not listed above? If yes, please list below.	☐ Yes ☐ No

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MEDICATIONS

Please list all medications, over the counter and herbal supplements, that you are currently taking (include medication name, dosage and frequency):

ALLERGIES/REACTIONS

Are you allergic to, or had a reaction to any of the following?

	Yes	No		Yes	No
Aspirin			Codeine		
Dental Anesthetics			Erythromycin		
Jewelry			Latex		
Metals			Penicillin		
Sulfa Drugs			Tetracycline		

Please list any allergy/reaction that you have or have had that is not listed above.

ADDITIONAL NOTES/COMMENTS:

FORM COMPLETION

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:		Date:	

IF PATIENT IS A MINOR

Form signed by:		Relationship to Patient:	

Doctor's Signature:		Date:	