New Smile Family Dentistry: Registration & Medical History Form

Patient Info

DATE: ___________________________________ PERSON RESPONSIBLE FOR ACCOUNT: ____

PATIENT FULL NAME: ____

PREFFERED NAME: ____ SOCIAL SECURITY #: _______________________________________

SEX: ( ) MALE ( ) FEMALE DATE OF BIRTH ____ AGE: _________________

( ) MARRIED ( ) SEPERATED ( ) DIVORCED ( ) WIDOW ( ) SINGLE ( ) MINOR ( ) PARTNERED FOR ________YEARS

ADDRESS: ____

CITY/TOWN: ____ STATE: _____________________ ZIP CODE: _________________________

*****Please check how you would prefer to be contacted & confirmed*****

( ) HOME PHONE: _________________________ ( ) CELL: ____________________________ ( ) WORK: ______________________

( ) OTHER: ____ ( ) TEXT: ____

( ) EMAIL: ____

EMPLOYER/SCHOOL: ____

Spouse, Parent or Guardian Info

SPOUSE/PARENTS/GUARDIAN FULL NAME:____

PREFFERED NAME: ____ SOCIAL SECURITY #: _____________________________________

RELATIONSHIP TO PATIENT: ( ) SPOUSE ( ) PARENT ( ) GRANDPARENT ( ) GUARDIAN ( ) Other _________________________

DATE OF BIRTH ____ AGE: ___________________________

ADDRESS: ____

CITY/TOWN: ____ STATE: __________________________ ZIP CODE: ____________________

SPOUSE/PARENTS/GUADIAN EMPLOYER: ____

*****Please check how you would prefer to be contacted & confirmed*****

( ) HOME PHONE: _________________________ ( ) CELL: ____________________________ ( ) WORK: _____________________

( ) OTHER: ____ ( ) TEXT: ____

( ) EMAIL: ____

IN CASE OF EMERGENCY CONTACT (someone who doesn't live in your household):

FULL NAME: ____ RELATIONSHIP:_____________________________________

( ) HOME PHONE: _______________________ ( ) CELL: ___________________________ ( ) WORK: _________________________

WHOM MAY WE THANK FOR REFERRING YOU:

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

( ) Bad breath
( ) Bleeding gums
( ) Blisters on lips or mouth
( ) Burning sensation on tongue
( ) Chew on one side of mouth
( ) Use tobacco of any kind
How much: _____________
( ) Clicking or popping jaw
( ) Dry mouth
( ) Fingernail biting
( ) Food collecting-between teeth
( ) Grind teeth
( ) Gums swollen or tender
( ) Jaw pain or tender
( ) Lip or cheek tender
( ) Loose teeth or broken fillings
( ) Missing teeth
( ) Mouth breather
( ) Mouth pain while brushing
( ) Orthodontic (Braces) treatment
( ) Pain in ear
( ) Periodontal (Gum) treatment
( ) Sensitive to cold
( ) Sensitive to heat
( ) Sensitive to sweets
( ) Sensitive to biting

Chief Concern for today's visit:
____
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HEALTH HISTORY:
Please check if you have or had any of the following:

( ) AIDS/HIV
( ) Abnormal bleeding
( ) Angina
( ) Anemia
( ) Arthritis
( ) Artificial heart valves
( ) Artificial joints
( ) Asthma
( ) Back problems
( ) Blood disease
( ) Cancer
( ) Cold sores or fever blisters
( ) Chemical dependency
( ) Chemotherapy
( ) Circulatory problems
( ) Congenital heart lesions
( ) Cortisone treatments
( ) Cough-persistent or bloody
( ) Diabetes
( ) Emphysema
( ) Epilepsy
( ) Fainting or dizziness
( ) Fibromyalgia
( ) Gags easily
( ) Headaches
( ) Heart bypass
( ) Heart murmur
( ) Heart problems
( ) Hemophilia
( ) Hepatitis __________
( ) Herpes
( ) High blood pressure
( ) Immune deficiency disease
( ) Jaundice
( ) Jaw Pain
( ) Kidney disease
( ) Liver disease
( ) Low blood pressure
( ) Mitral valve prolapse
( ) Organ transplant
( ) Pacemaker
( ) Polio
( ) Psychiatric care
( ) Radiation treatment
( ) Respiratory disease
( ) Rheumatic fever
( ) Scarlet fever
( ) Seasonal allergies
( ) Seizures
( ) Shortness of breath
( ) Sickle cell anemia
( ) Sinus trouble
( ) Skin rash
( ) Special diet
( ) Stints
( ) Stroke
( ) Swollen feet or ankles
( ) Swollen neck glands
( ) Thyroid problems
( ) Tonsillitis
( ) Tuberculosis
( ) Tumor
( ) Ulcer
( ) Venereal disease
( ) Wears contact lenses
( ) Weight loss (Unexplained)

WOMEN ONLY:
( ) Pregnant
Due: _____________
( ) Nursing

Allergies:
( ) Amoxicillin
( ) Aspirin
( ) Barbiturates (Sleeping pills)
( ) Codeine
( ) Iodine
( ) Keflex
( ) Latex
( ) Local Anesthetic
( ) Penicillin
( ) Other ______________________
( ) None

Medications
(Prescribed & Over the Counter)
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