New Patient Registration

Laura Manuel, D.D.S., Inc.

Patient Name: _____
First Middle Last

How would you like to be addressed? _____

Social Security # _____Drivers License # _____ Birth date____/____/____Age ____
Home Address: _____City:_____State_____Zip_____
Home Phone #_____Cell Phone #_____Email_____
Preferred Method of Contact for billing: □ Postal Mail □ Email
Preferred Method for Confirming Appointments □ Home Phone □ Cell Phone □ Work Phone □ Email
Marital Status: □ Single □ Married □ Divorced □ Widowed Spouse's Name: _____
Employer Name and Address _____
How did you hear about our practice? _____
Emergency Contact Person: _____ Relationship:_____
Home Phone #: _____Cell Phone #_____Work Phone #_____
Person Responsible for account (if not you)_____Relationship_____
Social Security #_____Drivers License #_____Occupation_____
Home Address (if different)_____
Employer and Address_____Occupation_____
Home Phone #_____Cell Phone #_____Work phone #_____
Current Dental Problems_____
Last dentist name and location_____
Why are you changing dentists?_____
When was your last dental visit?_____What was done then?_____
Is there anything you would like to speak about with the doctor in private? Y / N

Insurance Questions

Primary Dental Insurance Carrier
Insured Name:_____ Relationship to patient:_____
Date of Birth:_____/_____/_____ Insurance ID #:_____SSN:_____-_____-_____
Group #:_____Insurance Name:_____

Secondary Dental Insurance Carrier
Insured Name:_____ Relationship to patient:_____
Date of Birth:_____/_____/_____ Insurance ID #:_____SSN:_____-_____-_____
Group #:_____Insurance Name:_____

Dental Questions

1. Have you ever had a bad dental experience?……..Y / N
2. Do you feel nervous about having dental treatment?……..Y / N
3. Do you have any tooth or gum pain right now?……..Y / N
4. Do your gums bleed easily?……Y / N
5. Might you have bad breath?……Y / N
6. Are your teeth sensitive to hot or cold?……..Y / N
7. Any loose teeth?……..Y / N
8. Do you have the goal to keep all of your teeth the rest of your life?……..Y / N
9. Would you like to improve your smile?……..Y / N
   If so, what would you improve?_____
   _____
10. Would you like whiter teeth?……Y / N
11. Are your teeth as straight as you would like them?……Y / N

12. Do your teeth meet comfortably when you bite?……Y / N
13. Do you have pain in your jaw joints?……..Y / N
14. Have you ever taken the drugs □ Fen-Phen □ Redux □ Fosamax (Biphosphonate) □ Zometa □ Actonel □ Boniva □ Aredia □ Diet Drugs
15. Any other questions or comments you might have about the appearance of your teeth?

_____

_____

_____

Medical Questions

1. Are you presently under the care of a physician?……Y / N
   Physician's Name_____Phone #(____)_____-_____
2. Have you ever had high blood pressure?……..Y / N
3. Has a physician ever said you have heart trouble?……Y / N
4. Have you ever had excessive bleeding from a cut or tooth extraction?……Y / N
5. Have you ever had an anesthetic (either local or general)?……Y / N
6. Are you allergic to penicillin, Novocain or any other medication?……Y / N
   If so, what medications?_____
   _____
7. Are you allergic to anything other than medicine?…….Y / N
   If so, please explain_____
   _____
8. Have you ever been premedicated with antibiotics for your dental treatment?……..Y / N
9. Do you have or have you had any of the following:

Anemia…….Y / N	Seizures…….Y / N	Emphysema…….Y / N
Herpes……...Y / N	Hay Fever……..Y / N	Rheumatism…….Y / N
Stroke……Y / N	Implant……..Y / N	Chicken Pox…….Y / N
Ulcers……Y / N	Headaches…….Y / N	Bruise Easily……Y / N
Diabetes……Y / N	Glaucoma…….Y / N	Head Injuries……Y / N
Arthritis……Y / N	Tonsilitis……...Y / N	Heart Failure……Y / N
Asthma…….Y / N	Hemophilia……Y / N	Scarlet fever…….Y / N
Cancer……..Y / N	Cold Sores……..Y / N	Sinus Trouble……..Y / N
Heart Murmur...Y / N	Liver Disease….Y / N	Blood Disease……..Y / N
Heart Ailments..Y / N	Heart Attack…...Y / N	Cerebral Palsy……..Y / N
Drug Addiction.Y ./ N	Kidney Disease...Y / N	Chemotherapy……..Y / N
Mental Disorder.Y / N	Thyroid Disease..Y / N	Fainting Spells……..Y / N
Tuberculosis…...Y / N	Tumors……Y / N	Rheumatic Fever…...Y / N
HIV / Aids……..Y / N	Snoring……Y /N	Blood Transfusion….Y / N
Hepatitis…….Y / N	TMJ……Y / N	Phsychiatric Tmt……Y / N

10. Are you currently taking any medications?……Y / N
    If so, please list below:
    a) _____
    b) _____
    c) _____
    d) _____
    e) _____

Female Health Questions

1. Are you or could you be pregnant?……..…Y / N
   If so, how far along?_____
2. Are you breastfeeding?……Y / N
3. Are you taking birth control pills?……..Y / N

- ☐ I hereby acknowledge I have received a copy of this practice's **Notice of Privacy Practices.** I further understand that the practice will offer me updates to the Notice of Privacy Practices should it be amended, modified, or changes in any way.
- ☐ I have received a copy of **Dental Materials Fact Sheet** as required by law.
- ☐ To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

Date:_____/_____/_____ Signature:_____

CONSENT FOR TREATMENT: I hereby grant authority to the dentist in charge of the care of the patient whose name appears on this Health History Form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation: ant to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

Date:_____/_____/_____ Signature:_____

This Portion to Be Filled Out By Dental Professional*

Date	Blood Pressure	Pulse	Initials