ARLINGTON DENTAL BUILDING

NEW PATIENT REGISTRATION

NAME _____ DATE_____

First Middle Last

ADDRESS_____ E-MAIL_____

CITY_____ STATE _____ ZIP CODE _____

HOME PHONE _____CELL PHONE _____

BIRTHDATE _____ SEX_____ Social Security #_____

PLEASE CIRCLE WHICH APPLIES: Married Single Divorced Separated Widowed

EMPLOYER_____ OCCUPATION_____

BUSINESS ADDRESS_____ BUSINESS PHONE _____

IN CASE OF EMERGENCY WHO MAY WE CONTACT_____ _____

Name Phone Number

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE_____

PRIMARY DENTAL INSURANCE

POLICY HOLDER_____

EMPLOYED BY_____ OCCUPATION_____

RELATIONSHIP TO PATIENT_____ BIRTHDATE_____

ADDRESS (if different from patient) _____ PHONE_____

CITY _____ STATE _____ ZIP CODE _____ CELL PHONE _____

INSURANCE COMPANY_____ PHONE_____

GROUP # _____ SUBCRIBER_____

SECONDARY DENTAL INSURANCE

POLICY HOLDER_____

EMPLOYED BY _____OCCUPATION_____

RELATIONSHIP TO PATIENT_____ BIRTHDATE_____

ADDRESS (if different from patient) _____ PHONE_____

CITY _____ STATE _____ ZIP CODE _____ CELL PHONE _____

INSURANCE COMPANY_____ PHONE_____

GROUP # _____ SUBCRIBER_____

Please complete both sides of form

MEDICAL HISTORY

Are you under medical treatment currently?.....YES NO
Have you been hospitalized for any surgery or serious illness within the last 5 years?.....YES NO
Do you use tobacco or vape products?.....YES NO
Do you use any controlled substances?.....YES NO
Are you wearing contact lenses?.....YES NO
Are taking blood thinners of any kind? ……YES NO
If yes what type?_____
Are you taking any medication? Please list and include not prescription medicine……YES NO
_____
_____
_____

Woman only:
Are you pregnant?.....YES NO Nursing?.....YES NO
Are you taking oral contraceptives ……YES NO

Do you have any artificial joints/implants/?.....YES NO
Do you have to premedicate for dental Procedures?..... YES NO

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

Local anesthetics (e.g novocaine)……..YES NO
Penicillin or any other antibiotics……..YES NO
Sulfa Drugs……YES NO
Barbiturates……..YES NO
Sedatives……..…YES NO
Iodine……..…YES NO
Aspirin……..YES NO
Any metals? (e.g. nickel, mercury, etc.)...YES NO
Latex Rubber……..YES NO
Peanut or tree nut ……YES NO
Other_____

Heart Disease……..YES NO
High Blood Pressure……..YES NO
Heart Attack……YES NO
Rheumatic Fever……YES NO
Swollen Ankles……..YES NO
Fainting/Seizures……..YES NO
Mitral Valve prolapse……YES NO
Low Blood Pressure……YES NO
Epilepsy/Convulsions……YES NO
Leukemia……YES NO
Diabetes……YES NO
Thyroid Problem……..YES NO

Cardiac Pacemaker……YES NO
Heart Murmur……..YES NO
Angina……YES NO
Frequently tired……..YES NO
Chest pains……YES NO
Easily winded……..YES NO
Hepatitis/Jaundice……..YES NO
Stomach Trouble……YES NO
STD……YES NO
Arthritis……..YES NO
Anemia……YES NO
Emphysema……YES NO

Asthma……..YES NO
Respiratory problems……YES NO
Tuberculosis……..YES NO
Cancer……YES NO
Radiation therapy……..YES NO
Recent Weight Loss……YES NO
Liver Disease……..YES NO
Kidney Disease……YES NO
AIDS/HIV……..YES NO
Other _____YES NO
_____
_____

PATIENT DENTAL HISTORY

Name of Previous Dentist_____ Date of last exam_____

Do your gums bleed while brushing or flossing……YES NO
Are your teeth sensitive to hot/cold/sweet/sour?…..YES NO
Do you feel pain in any of your teeth?……YES NO
Do you have any lumps or sores in your mouth?……YES NO
Have you had head, neck, or jaw injuries?…… YES NO
Do you clench or grind your teeth?……YES NO
Do you bite your cheeks or lips frequently?…… YES NO

Have you had difficult extractions in the past?……..YES NO
Have you had excessive bleeding ……..YES NO
following an extraction?…… YES NO
Have you had orthodontic treatment?……YES NO
Do you wear Dentures or partials?……YES NO
Do you like your smile?……YES NO

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

X_____
Signature of patient date