We would like to thank you for selecting our office as your dental care provider. Please take the time to complete the following documents accurately so we may better serve you. If you have any questions or would like to discuss any of the items listed below, any of us would be glad to assist you.

## NEW PATIENT REGISTRATION AND HEALTH HISTORY

Date_____

First Name_____ MI___ Last Name_____ How you preferred to be addressed?_____

Mailing Address_____City_____State_____Zip_____

Sex: M F Age _____ Birth date _____ Status: Single Married Widow Separated Divorced

Home Phone_____ Work Phone_____ Cell Phone _____

SS# _____ Occupation_____Employer_____

Employer's Address_____City_____State_____

If Student, name of School/College_____City_____State_____

Emergency Contact Name and Phone Number_____

Whom may we thank for referring you to our office?_____

**If the person responsible for this patient's account is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section titled "Dental Insurance Information."**

Responsible Party's Full Name_____ Relationship to Patient_____

Mailing Address_____City_____State_____Zip_____

Sex: M F Age _____ Birth date _____ Status: Single Married Widow Separated Divorced

SS#_____ Home Phone Number_____ Work Phone Number_____

## DENTAL INSURANCE INFORMATION

Policy Holder_____ Relationship to Patient_____ SS#_____DOB_____

Employer_____ Employee Address_____ State_____

Dental Ins. Co._____ Group#_____ Address_____

## SECONDARY DENTAL INSURANCE INFORMATION

Policy Holder_____ Relationship to Patient_____ SS#_____DOB_____

Employer_____ Employee Address_____ State_____

Dental Ins. Co._____ Group#_____ Address_____

**Answers to the following questions are for our records only and will be considered confidential.**

## PATIENT HISTORY

1. Have you or any member of your family been seen by us before? **Yes** **No**

   If yes, which family member(s)? _____

2. Date of last physical examination_____ Physician's Name_____

3. Date of last dental examination_____ Date of last dental x-rays_____

4. Previous Dentist_____ City/State_____

5. Are you having pain or discomfort at this time? **Yes** **No**

6. Do you feel nervous about having dental treatment? **Yes** **No**

7. Have you ever had a bad experience in a dental office? **Yes** **No**

8. Is there anything you would like to speak with the Doctor about in private? **Yes** **No**

9. Have you been a patient in the hospital during the past two years? **Yes** **No**

10. Have you been under the care of a medical doctor during the past two years? **Yes** **No**

11. Are you taking any vitamins, herbal supplements or recreational drugs? **Yes** **No**

12. Have you ever had any excessive or abnormal bleeding? **Yes** **No**

13. Have you ever had any surgeries? **Yes** **No**

14. Have you ever taken any of the following medications: Goserelin (Zoladex), Denosumab (Prolia), bisphosphonates [Etidronate (Didronel), Pamidronate (Aredia), Alendronate (Fosamax), Risedronate (Actonel), Zoledronate (Zometa), Ibandronate (Boniva), Tiludronate (Skelid), Zoledronic Acid (Reclast)]? **Yes** **No**

Please elaborate on any "Yes" answers above_____

_____

**Place a mark on yes or no to indicate if you have had any of the following:**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Artificial Heart Valve | **Yes** | **No** | Shortness of Breath | **Yes** | **No** | Hives or skin rash | **Yes** | **No** |
| Heart Failure | **Yes** | **No** | Ulcers | **Yes** | **No** | Alcoholism | **Yes** | **No** |
| Heart Disease or Attack | **Yes** | **No** | Mental Retardation | **Yes** | **No** | Herpes | **Yes** | **No** |
| Angina Pectoris/Chest Pain | **Yes** | **No** | Emphysema | **Yes** | **No** | Glaucoma or Cataracts | **Yes** | **No** |
| Heart Problems | **Yes** | **No** | Fainting or dizzy spells | **Yes** | **No** | *Steroid Treatment | **Yes** | **No** |
| Liver Disease | **Yes** | **No** | Eating Disorder | **Yes** | **No** | Arthritis | **Yes** | **No** |
| Heart Surgery | **Yes** | **No** | Epilepsy or seizures | **Yes** | **No** | *Any type of implant | **Yes** | **No** |
| High Blood Pressure | **Yes** | **No** | Persistent Cough | **Yes** | **No** | Dentures or Partials | **Yes** | **No** |
| *Heart Murmur | **Yes** | **No** | Tuberculosis (TB) | **Yes** | **No** | Birth defects | **Yes** | **No** |
| *Rheumatic Fever | **Yes** | **No** | Asthma | **Yes** | **No** | HIV, ARC, AIDS | **Yes** | **No** |
| Psychiatric treatment | **Yes** | **No** | *Congenital Heart Disorder | **Yes** | **No** | Hay fever | **Yes** | **No** |
| Sickle Cell Disease | **Yes** | **No** | Hepatitis A (Infectious) | **Yes** | **No** | Use of tobacco products | **Yes** | **No** |
| Sinus Trouble | **Yes** | **No** | Hepatitis B (Serum) | **Yes** | **No** | Bruise easily | **Yes** | **No** |
| *Artificial Joints | **Yes** | **No** | Hepatitis C or other | **Yes** | **No** | Jaundice | **Yes** | **No** |
| Thyroid Disease | **Yes** | **No** | Heart pacemaker | **Yes** | **No** | C.O.P.D. | **Yes** | **No** |
| Anemia | **Yes** | **No** | Stroke | **Yes** | **No** | Kidney Disease | **Yes** | **No** |
| Blood transfusion | **Yes** | **No** | Drug addiction | **Yes** | **No** | Hemophilia | **Yes** | **No** |
| *Any type of transplant | **Yes** | **No** | Autoimmune Disease | **Yes** | **No** | Diabetes | **Yes** | **No** |
| *Mitral Valve Prolapse | **Yes** | **No** | Radiation Therapy | **Yes** | **No** | Chemotherapy | **Yes** | **No** |
| High Cholesterol | **Yes** | **No** | Venereal Disease | **Yes** | **No** | Platelet Disorder | **Yes** | **No** |
| Factor Deficiency | **Yes** | **No** | Gastrointestinal Disease | **Yes** | **No** | Cancer (type: ) | **Yes** | **No** |

***Antibiotic pre-medication may be required prior to your appointment.**

Do you have any diseases, conditions or problems not listed above? _____

**MEDICAL ALLERGIES**

Aspirin
NSAIDs
Codeine/Narcotics
Iodine
Latex
Local Anesthetic
Penicillin
Sulfa
Metals
Other_____

**MEDICATIONS**

Please list medications you are currently taking:
_____
_____
_____

Pharmacy:_____

## DENTAL HISTORY

| | | |
|---|---|---|
| 1. Have you ever been treated for periodontal or gum disease? | **Yes** | **No** |
| 2. Do your gums bleed when you brush your teeth? | **Yes** | **No** |
| 3. Do you have a problem with halitosis (bad breath)? | **Yes** | **No** |
| 4. Do you grind or clench your teeth? | **Yes** | **No** |
| 5. Have you ever had any problems with your jaw or TMJ? | **Yes** | **No** |
| 6. Have you often had toothaches? | **Yes** | **No** |
| 7. Have you had frequent sores, lumps or growths in your mouth? | **Yes** | **No** |
| 8. Have you had any injuries to your mouth or jaws?<br>If so, please explain_____<br>_____ | **Yes** | **No** |
| 9. Do you have any sores or swellings of your mouth or jaws? | **Yes** | **No** |
| 10. Would you like oral hygiene instructions? | **Yes** | **No** |
| 11. Have you been unsatisfied with your previous dental care?<br>If so, please explain_____<br>_____ | **Yes** | **No** |
| 12. Is there anything you dislike about your smile?<br>If so, please explain_____ | **Yes** | **No** |
| 13. Do you have any dental concerns not listed above?<br>If so, please explain_____ | **Yes** | **No** |

| | | | |
|---|---|---|---|
| WOMEN: Are you pregnant now? | **Yes** | **No** | If yes, when is your due date? _____ |
| Are you currently breast-feeding? | **Yes** | **No** | |
| Are you taking oral contraceptives? | **Yes** | **No** | |

I certify that I have read and understood the above information. The above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I authorize the use of my signature below for Smile Shoppe to keep as a "Signature on File" for filing of insurance claims, and I authorize the use of my name for claims made on my behalf or my dependents.

X_____
Signature of Patient or Guardian Date