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Give Your Dental Wellness a Second Chance
www.smilereborn.com

NEW PATIENT REGISTRATION FORM

Today's Date: _____

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Name: _____
I prefer to be called: _____
Age_____ Birthdate: _____
Social Security Number: _____

Home Phone: (____)_____
Work Phone: (____)_____
Cell Phone: (____)_____
Email Address: _____

Street Address _____
City _____ State_____
ZIP_____

Preferred contact method:
□ Home Phone □ Work Phone □ Cell Phone
□ Cell Phone Text Message □ Email

Employer_____ Occupation_____

Gender (circle): Male / Female / Other

Single / Married / Minor / Windowed / Divorced / Separated

Name of Spouse: _____
If you are a minor: Mother's Name: _____ Birthdate: _____
Father's Name: _____ Birthdate: _____
Please list other family members who are also patients in our practice _____

Disability (circle): No / Yes
If yes, please indicate: □ Partial □ Total □ Temporary □ Permanent
How can we accommodate to your needs? _____

Where did you hear about our office: _____
Who may we thank for referring you? _____

Emergency Contacts:
Name: _____ Relationship: _____ Phone: (____)_____
Name: _____ Relationship: _____ Phone: (____)_____

Person Financially Responsible (if it is someone other than the patient)
Name: _____ Relationship to Patient: _____
Social Security Number: _____ Birthdate: _____ Phone: (____)_____
Street Address: _____ City: _____ State: ____ Zip:_____

DENTAL INSURANCE INFORMATION

Policy Subscriber Name: _____ Subscriber Birthdate _____ (m/d/yr) Subscriber's Employer: _____
Insurance Carrier Name: _____ Plan Group #: _____ Subscriber ID #/SSN: _____
Patient Relationship to Subscriber: Self / Spouse / Dependent / Other: _____
Insurance Carrier Mailing Address: _____ Insurance Carrier Phone: (____) _____

If applicable, please fill out the secondary insurance benefit information below:

Policy Subscriber Name: _____ Subscriber Birthdate _____ (m/d/yr) Subscriber's Employer: _____
Insurance Carrier Name: _____ Plan Group #: _____ Subscriber ID #/SSN: _____
Patient Relationship to Subscriber: Self / Spouse / Dependent / Other: _____
Insurance Carrier Mailing Address: _____ Insurance Carrier Phone: (____) _____

MEDICAL HISTORY

Date of last physical _____
Name of personal physician _____ Phone # _____
How do you assess your current health? ____Excellent ____Good ____Fair ____Poor
Are you currently under the care of a physician? ___Yes ___No If yes, why? _____
Have you gone to the hospital or emergency room or had a serious illness in the last three years
If YES, explain: _____

Please mark any that apply both history or present:

AIDS/HIV	Yes	Heart Murmur	Yes	Transplants	Yes
Anemia	Yes	Heart problems	Yes	Tuberculosis	Yes
Arthritis, rheumatism	Yes	Hepatitis Type ___	Yes	Tumor/growth in head	Yes
Artificial heart valves	Yes	Herpes	Yes	Ulcer	Yes
Artificial joints	Yes	High blood pressure	Yes	Sleep apnea	Yes
Asthma	Yes	Kidney disease	Yes		
Bell's palsy	Yes	Liver disease	Yes	Headaches	Yes
Bleeding abnormally	Yes	Mitral valve prolapse	Yes	Jaw pain	Yes
Blood disease	Yes	Nervous problems	Yes	Jaw popping	Yes
Cancer	Yes	Pacemaker	Yes	Limited jaw opening	Yes
Canker/cold sores	Yes	Psychiatric care	Yes	Congested ears	Yes
Chemotherapy	Yes	Radiation treatment	Yes	Posture problems	Yes
Circulatory problems	Yes	Rheumatic fever	Yes	Clenching	Yes
Cortisone treatments	Yes	Scarlet fever	Yes	Grinding	Yes
Cough, persistent	Yes	Seizures	Yes	Facial pain	Yes
Depression	Yes	Sinus trouble	Yes	Neck ache	Yes
Diabetes	Yes	Stroke	Yes		
Epilepsy	Yes	Swollen feet or ankles	Yes	Other medical issues	Yes
Fainting or dizziness	Yes	Swollen neck glands	Yes	Surgeries	Yes
Glaucoma	Yes	Thyroid problems	Yes		
Heart lesions	Yes	Tonsilitis	Yes		

Please describe any of the above medical problems in greater detail: _____

Are you currently taking prescription medications? If YES, please list below (name and purpose)
_____

Please list any allergies:
□ Aspirin □ Valium/other sedatives □ Codeine/other narcotics □ Penicillin/other antibiotics
□ Latex □ Metal □ Nitrous oxide □ Local anesthetics
□ Food (type: _____) □ Other _____

Have you taken or currently taking medications for osteoporosis known as bisphosphonates
(e.g. Fosamax, Actonel, or Boniva)? If YES, what medications _____

Do you smoke or use chewing tobacco? How much? How many months or years? _____

Have you seen a □ Chiropractor □ Neurologist □ Massage Therapist □ ENT

Do you snore, use a CPAP or have had a sleep study? If yes, please describe: _____
Insomnia (Yes/No) Less than 7 hours of sleep per night (Yes/No)
How many times do you get up at night? ____ Your height _____ neck circumference _____

Women only
Are you or could you be pregnant? Yes If YES, what month? _____
Are you nursing? Yes
Are you taking birth control pills? Yes

DENTAL HISTORY

Reason for today's visit? _____
Date of last dental visit? _____
Date of last dental x-rays? _____

Family Dentist: _____
Address:_____ Phone: (____)_____ Email: _____
If you left your previous dentist, what was the reason? _____
What are your goals in coming to our practice today? _____
What is important to you in a dentist or dental practice? _____

At-Home Oral Hygiene Care
How often do you brush your teeth? _____
How often do you floss? _____
Do you use mouthwash? Yes / No
If YES, which kind: _____
Do you use any other dental home care products? Yes / No
If YES, which kind: _____

- How important is your dental health to you?
  (Not concerned) 1-2-3-4-5 (Extremely)
- Where would you rate your current dental health?
  (Poor) 1-2-3-4-5 (Excellent)
- How important is your overall health?
  (Not concerned) 1-2-3-4-5 (Extremely)
- How important is preventive care to you?
  (Not concerned) 1-2-3-4-5 (Extremely)

Circle Appropriate Answer (Leave blank if it doesn't apply)

Yes / No Are you currently experiencing dental pain or discomfort?
If YES, explain: _____
Yes / No Do your gums bleed?
If YES, where in your mouth? _____
Yes / No Are your teeth loose?
If YES, where in your mouth? _____
Yes / No Do you wear dentures or partials?
Yes / No Have you ever been told you have gum disease?
Yes / No Are your teeth sensitive to hot, cold, sweets or pressure?
Yes / No Have your ever had any clicking, popping or discomfort in the jaw?
Yes / No Do you grind your teeth during sleep?
Yes / No Do you clench and keep your teeth together throughout the day?
Yes / No Do you wear a bite guard?
Yes / No Have you ever had braces before?
Yes / No Do you have dry mouth?
Yes / No Does food or floss catch between your teeth?
If YES, where in your mouth? _____
Yes / No Have you had any problems or an upsetting dental experience associated with previous dental care?
Yes / No Are you fearful of dentistry or have anxiety associated with dental treatment?
Yes / No Have you ever been pre-medicated for dental treatment?
Yes / No Have you ever had a reaction to anesthetic used with your dental treatment?
If YES, what is it? _____
Yes / No Are you happy with your smile?
If NOT, what would you change about the present condition of your mouth?
_____

Is there anything else you would like us to know about your dental health or dental history? _____

❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful dental history and that my dentist and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.

_____ _____
Signature of Patient (Parent or Guardian) Date

PATIENT ACKNOWLEDGEMENTS AND AUTHORIZATIONS

You May Refuse to Sign This Acknowledgement

❖ I have read and agree to the dental treatment, financial, scheduling, office policies, and communication terms. _____ (initial)

☐ I prefer to receive information via the practice's secure and encrypted email ONLY. I understand that this communication method may cause slight delay but I may always provide consent later.

❖ I authorize the release of information necessary to process my dental insurance benefit claims. I hereby authorize payment directly to this doctor. _____ (initial)

❖ I authorize the possible uses of photos/videos/x-ray films for dental research, professional publication, education, and the endorsement of the dental practice (website, printed materials, and patient education) _____ (initial)

☐ I authorize the use of records with confidentiality but do not wish my full face photos/videos to be used for any of the above purposes.

❖ I hereby acknowledge that a copy of this practice's **Notice of Privacy Practices (HIPPA)** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. _____ (initial)

❖ I hereby acknowledge that a copy of this practice's **Dental Materials Fact Sheet** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. _____ (initial)

❖ I hereby acknowledge that a copy of this practice's **Office Policies** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. _____ (initial)

❖ I hereby acknowledge that a copy of this practice's **Treatment Warranty** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. _____ (initial)

Print Name: _____

Signature: _____

Date: _____

If signed by a personal representative on behalf of the patient

Representative's Name: _____Relationship to Patient: _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY

Acknowledgements and authorizations could not be obtained because:

□ Individual refused to sign
□ Communications barriers prohibited obtaining the acknowledgement
□ An emergency situation prevented us from obtaining acknowledgement
□ Other (Please Specify)