New Patient Registration

ABOUT YOU

Name: _____ _____ _____
Last First Mid

If below 18 years of age;

Father's name:_____
Telephone #: (___) -___ - ___
Mother's name:_____
Telephone #: (___) -___ -___
Other: _____
Telephone #: (___) - ___ - ___
I prefer to be called:_____
Your birthday: ___/___/___ Age: ____ SSN: ___-___-___
Home address:_____ APT#:_____
City: _____ State: _____ Zip: _____
Your marital status: ☐Single ☐Married ☐Widowed
☐*Divorced* ☐*Separated* ☐*Minor*

Email address:_____ Sex:____
Home phone #: (___) -___ - ___ Cell Phone #: (___) -___ - ___
Work Phone #: (___) -___ -____ Ext: ____
Employer: _____
Occupation :_____
How did you hear about us?_____
Have you visited our website?_____
Whom may we **THANK** for referring you? _____
How would you like us to confirm appointments? Mark all that apply:
☐ Home ☐Work ☐Cell ☐E-mail ☐ Text

Spouse/Partner information

His / Her name:_____
Employer:_____
Work phone #: (___) -___ - ____ Ext:____ Cell #: (___) -___ - ___
SSN: ___-___-___ Birthday :___/___/___

Nearest friend/relative to contact in case of emergency (not living with you)

His / Her name:_____
Relationship: _____
Home Phone #: (___) -___ - ___ Work #: (___) -___ - ____ Ext:____

INSURANCE INFORMATION

Primary insurance

Insurance Co. name: _____
Insurance Co. Phone #: (___) -___ - ___
Subscriber's name: _____
Relationship: ☐Self ☐Spouse ☐Child
Subscriber's Birthday:___/___/___Subscriber's SSN: ___-___-___
Subscriber's ID#:_____ Group#:_____
Subscriber's employer:_____

Secondary insurance

Insurance Co. name: _____
Insurance Co. Phone: (___) -___ - ___
Subscriber's name: _____
Relationship: ☐Self ☐Spouse ☐Child
Subscriber's Birthday:___/___/___Subscriber's SSN:___-___-___
Subscriber's ID#:_____ Group#: _____
Subscriber's employer:_____

HEALTH AND DENTAL HISTORY

Health problems and/or medications you are taking may make a difference in how we treat you to maintain your dental health. Thanks for answering all of the following questions:

Physician's Name:_____
Telephone # : (___) -___ -___
Have you ever worn braces ?☐Yes ☐No When:_____
Have you been under the care of a medical doctor during the past two years ? ☐Yes ☐No
Have you had any surgeries? If so, list all surgeries?

Date	**Type**

Have you ever taken Fosamax, Actonel, Boniva ?☐Yes ☐No
Which one ?_____
Have you ever taken Phen-Fen or Redux ?☐Yes ☐No
Have you ever experienced physical trauma to your upper body ? ☐Yes ☐No
Do you use tobacco products ? ☐Yes ☐No
When was your last visit to see the dentist/hygienist ? ☐Yes ☐No
Have you consulted another health care provider(s) for this problem ? ☐Yes ☐ No
Do your gums bleed ?☐Yes ☐No
Does your physician require prophylactic antibiotics (pre-medication) prior to dental care?☐Yes ☐No
If yes, Please explain
_____
_____
_____
_____
Have you ever worn a night guard or mouth splint ?☐Yes ☐No

In order to take good care of you, please list all medicines, (include over the counter products, and supplements) that you are currently taking. All supplements have side effects. If you take it, we need to know.

Medicine or Supplement	**Dose**	**Medical Condition**	**Notes**

Indicate which of the following you have had, or have at present

	Yes	No
AIDS / HIV	☐	☐
Hepatitis ☐ A ☐ B ☐ C ☐ D	☐	☐
Mitral Valve Prolapse	☐	☐
Artificial Joints	☐	☐
☐ Hip **Date**: _____		
☐ Knee **Date**: _____		
☐ Ankle **Date**: _____		
☐ Shoulder **Date**: _____		
Heart Murmur	☐	☐
Rheumatic Fever	☐	☐
Date: _____		
Anemia / Blood Disorder	☐	☐
Asthma / Respiratory Disorder	☐	☐
Artificial Heart Valve / Heart Bypass	☐	☐
Date: _____		
Alzheimer's Disease	☐	☐
Arthritis/Gout	☐	☐
Bell's Palsy	☐	☐
Bleeding Problems	☐	☐
Blood Pressure ☐High ☐Low	☐	☐
Cancer	☐	☐
Type: _____ **Date**: _____		
Chemotherapy	☐	☐
Radiation	☐	☐
Congenital Heart Disease	☐	☐
Convulsions	☐	☐
Cold Sores/Fever Blisters	☐	☐
Diabetes ☐Type 1 ☐Type 2	☐	☐
Epilepsy / Seizures	☐	☐
Frequent Coughing	☐	☐
Genital Herpes	☐	☐
Glaucoma	☐	☐
Heart Attack	☐	☐
Date: _____		
Heart pacemaker	☐	☐
Heart trouble/Disease	☐	☐
Hayfever	☐	☐
Herpes	☐	☐

	Yes	No
High Cholesterol	☐	☐
Hypoglycemia	☐	☐
Insomnia / Frequent waking	☐	☐
Irregular Heartbeat	☐	☐
Kidney problems	☐	☐
Liver Disease / Jaundice	☐	☐
Leukemia	☐	☐
Lung Disease	☐	☐
Neurological Disorders	☐	☐
Psychiatric / Psychological	☐	☐
Posture Problems	☐	☐
Stroke	☐	☐
Date: _____		
Stents	☐	☐
Date: _____		
Sickle Cell Disease	☐	☐
Shingles	☐	☐
Tuberculosis	☐	☐
Trigeminal Neuralgia	☐	☐
Thyroid Disease	☐	☐
Venereal Disease	☐	☐

Congested Ears/Or Pain	☐	☐
Clenching/Grinding	☐	☐
Dizziness/Fainting spells	☐	☐
Difficulty Swallowing/Chewing	☐	☐
Facial Pain	☐	☐
Headaches	☐	☐
Jaw Pain	☐	☐
Jaw Popping/Clenching	☐	☐
Neck Pain	☐	☐
Ringing Ears	☐	☐
Limited Jaw Opening	☐	☐
Loose Teeth	☐	☐
Sensitive Teeth	☐	☐
Snoring	☐	☐
Sleep Apnea	☐	☐
Tingling in arms / fingers	☐	☐
Temporalarteritis	☐	☐

ALLERGIES TO ANY MEDICATIONS

☐ Penicillin ☐ Latex ☐ Codeine ☐ Metals
☐ Sulfa ☐ Food ☐ Aspirin ☐ Local Anesthetics

List Other Allergies

_____
_____
_____
_____

Do you have or have had any disease, condition or problem not listed above ?

_____
_____
_____
_____

Have you ever had any adult teeth extracted ? ☐Yes ☐No
If yes, Did you have any healing problems or prolonged bleeding ? ☐Yes ☐No

Female Patients - Are you Pregnant? ☐Yes ☐No

By typing (or signing) in my name _____, I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. I authorize Dr.Brossoit 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 payers and/or other health practitioners. I authorize and request my insurance company to pay directly to Dr.Brossoit 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 to me or my dependents.

☐ I authorize Dr. Brossoit to use my picture/and or photos of my mouth and teeth for advertising and/or marketing in print or on our website

Typed Signature : _____ Date : _____

OFFICE USE ONLY :

Updated: _____ Initials: _____ Date:_____
Updated: _____ Initials: _____ Date:_____
Doctor's Comments:

_____
_____