



NEW PATIENTS / 01

Patient Registration

Date

First Name

Last Name

Birthdate

Social Security

Marital Status

☐ Single

☐ Married

Address

City

State

Zip

Cell Phone Number

Home Phone Number

Email

Referred By

Parent / Legal Guardian

Please complete if you are the legal guardian of a patient below the age of 18:

Guardian First Name

Last Name

Birthdate

Social Security

Marital Status

☐ Single

☐ Married

Dental Insurance

Insurance Company

Policy Holder's Name

Policy Holder's DOB

Patient's relationship to the Policy Holder

Employer's Name

Group Number

Member ID



NEW PATIENTS / 02

Medical Health History

Physician's Name

Phone Number

1. Have you had any medical care within the past two years?

☐ Yes ☐ No

Explain:

2. Have you taken any medication or drugs during the past two years?

☐ Yes ☐ No

If yes, please list names and dosage:

3. Are you currently taking any medication, drugs, pills, or herbal remedies, including regular dosage of aspirin?

☐ Yes ☐ No

If yes, please list names and dosage:

4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva, or other bisphosphonates?

☐ Yes ☐ No

If yes, please list names and dosage:

5. Are you aware of having any allergic reaction to any substance or medication?

☐ Yes ☐ No

If yes, please specify:

6. Have you been a patient in the hospital during the past five years?

☐ Yes ☐ No

7. Have you gained or lost more than 10 pounds in the past year?

☐ Yes ☐ No

8. Women: Are you pregnant or think you could be pregnant?

☐ Yes ☐ No

If yes, please specify:

9. Do you use birth control prescriptions?

☐ Yes ☐ No

10. Smoke/chew tobacco or use other tobacco products?

☐ Yes ☐ No



NEW PATIENTS / 03

Medical Health History

11. Indicate which of the following you have had, or have present.

Select Y or N for each condition.

Heart Disease	☐ Y ☐ N	Cancer	☐ Y ☐ N	Sickle Cell	☐ Y ☐ N
Heart Murmur	☐ Y ☐ N	Ulcers	☐ Y ☐ N	Tumors	☐ Y ☐ N
Artificial Pacemaker	☐ Y ☐ N	Diabetes	☐ Y ☐ N	AIDS/HIV	☐ Y ☐ N
Mitral V. Prolapse	☐ Y ☐ N	Asthma	☐ Y ☐ N	Sinus Trouble	☐ Y ☐ N
High/Low BP	☐ Y ☐ N	Glaucoma	☐ Y ☐ N	Bruise Easily	☐ Y ☐ N
Chest Pain	☐ Y ☐ N	Contacts	☐ Y ☐ N	Venereal Disease	☐ Y ☐ N
Rheumatic Fever	☐ Y ☐ N	Emphysema	☐ Y ☐ N	Chemotherapy	☐ Y ☐ N
Arthritis/ Rheumatism	☐ Y ☐ N	Tuberculosis	☐ Y ☐ N	Cold Sores	☐ Y ☐ N
Cortisone Medicine	☐ Y ☐ N	Chronic Cough	☐ Y ☐ N	Blood Transfusion	☐ Y ☐ N
Swollen Ankles	☐ Y ☐ N	Thyroid Issues	☐ Y ☐ N	Hemophilia	☐ Y ☐ N
Stroke	☐ Y ☐ N	Kidney Trouble	☐ Y ☐ N	Radiation Therapy	☐ Y ☐ N
Artificial Joints	☐ Y ☐ N	Latex Sensitivity	☐ Y ☐ N	Hepatitis A B C	☐ Y ☐ N
Liver Disease	☐ Y ☐ N	Hay Fever/Hives	☐ Y ☐ N	Neurological Dis.	☐ Y ☐ N
Fainting/Dizzy Spells	☐ Y ☐ N	Nervous Anxious	☐ Y ☐ N	Psychiatric Care	☐ Y ☐ N

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

☐ Yes ☐ No

If yes, please specify:

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. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient/Guardian Signature

Date

Dentist Signature

Date



NEW PATIENTS / 04

Dental History

What is the reason for your visit today?

Date of last dental visit

Last Dental Cleaning

Last X-Rays

What was done at the last dental visit?

Previous Dentist Name

Phone Number

How often do you have dental examinations?

How often do you brush?

Have you ever used or currently using topical fluoride?

What other dental aids do you use?

Have you noticed any mouth odors or bad taste?

☐ Yes ☐ No

Do you get frequent cold sores, blisters, or other oral lesions?

☐ Yes ☐ No

Do you have sensitivity to (hot/cold, sweets, bite/chewing)?

☐ Yes ☐ No

Does your gum bleed or hurt?

☐ Yes ☐ No

Have you noticed any loose teeth or changes in your bite?

☐ Yes ☐ No

Does food get caught in between your teeth?

☐ Yes ☐ No

Do you clench and grind your teeth while awake or asleep?

☐ Yes ☐ No

Mouth breathe while awake or asleep?

☐ Yes ☐ No

Snore or have other sleeping disorders?

☐ Yes ☐ No

Have any jaw joint (TMJ) problems?

☐ Yes ☐ No



NEW PATIENTS / 05

Consent for Treatment

1. I hereby authorize Dr. or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by Dr. Pooya to make a thorough diagnosis of (name of patient)

_____'s dental needs.

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to Dr. Pooya or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1 ½% late charge (18% APR) may be added to my account. If required, I also understand that a check of my credit history may be made.

6. Cell Phone:

☐ I consent to the dental practice using my cell phone number to (choose one or both)

☐ Call

☐ Text

regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

My cell phone number (include area code)

Patient/Responsible Party's Signature

Date
