

# 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: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Sex: \_\_\_\_\_

Home address: \_\_\_\_\_ APT#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Your marital status:  Single  Married  Widowed  Divorced  Separated  Minor

Email address: \_\_\_\_\_

Home phone #: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Cell Phone #: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_

Work Phone #: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Ext: \_\_\_\_

Employer: \_\_\_\_\_

Occupation : \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ Have you visited our website?  Yes  No

Whom may we **THANK** for referring you? \_\_\_\_\_

How would you like us to confirm appointments? Mark all that apply:

Home  Work  Cell  E-mail

### 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: \_\_\_\_\_ Phone #: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_

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?

<b>Date</b>	<b>Type</b>
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever taken Fosamax, Actonel, Boniva ?  Yes  No Which one ?  Fosamax,  Actonel,  Boniva

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? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Have you consulted another health care provider(s) for this problem ?  Yes  No

Do your gums bleed ?  Yes  No

Have you ever worn a night guard or mouth splint ?  Yes  No

Does your physician require prophylactic antibiotics (pre-medication) prior to dental care?  Yes  No

If yes, Please explain

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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		Yes/No		Yes/No
AIDS / HIV	<input type="checkbox"/> <input type="checkbox"/>	Cold Sores/Fever Blisters	<input type="checkbox"/> <input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/> <input type="checkbox"/>
Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D	<input type="checkbox"/> <input type="checkbox"/>	Diabetes _____	<input type="checkbox"/> <input type="checkbox"/>	Shingles	<input type="checkbox"/> <input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/> <input type="checkbox"/>	Epilepsy / Seizures	<input type="checkbox"/> <input type="checkbox"/>	Tuberculosis	<input type="checkbox"/> <input type="checkbox"/>
Artificial Joints	<input type="checkbox"/> <input type="checkbox"/>	Frequent Coughing	<input type="checkbox"/> <input type="checkbox"/>	Trigeminal Neuralgia	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Hip <b>Date :</b> _____		Genital Herpes	<input type="checkbox"/> <input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Knee <b>Date :</b> _____		Glaucoma	<input type="checkbox"/> <input type="checkbox"/>	Venereal Disease	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Ankle <b>Date :</b> _____		Heart Attack	<input type="checkbox"/> <input type="checkbox"/>	Congested Ears/Or Pain <input type="checkbox"/> <input type="checkbox"/> Clenching/Grinding <input type="checkbox"/> <input type="checkbox"/> Dizziness/Fainting spells <input type="checkbox"/> <input type="checkbox"/> Difficulty Swallowing/Chewing <input type="checkbox"/> <input type="checkbox"/> Facial Pain <input type="checkbox"/> <input type="checkbox"/> Headaches <input type="checkbox"/> <input type="checkbox"/> Jaw Pain <input type="checkbox"/> <input type="checkbox"/> Jaw Popping/Clenching <input type="checkbox"/> <input type="checkbox"/> Neck Pain <input type="checkbox"/> <input type="checkbox"/> Ringing Ears <input type="checkbox"/> <input type="checkbox"/> Limited Jaw Opening <input type="checkbox"/> <input type="checkbox"/> Loose Teeth <input type="checkbox"/> <input type="checkbox"/> Sensitive Teeth <input type="checkbox"/> <input type="checkbox"/> Snoring <input type="checkbox"/> <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> <input type="checkbox"/> Tingling in arms / fingers <input type="checkbox"/> <input type="checkbox"/> Temporalarteritis <input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/> Shoulder <b>Date :</b> _____		<b>Date :</b> _____			
Heart Murmur	<input type="checkbox"/> <input type="checkbox"/>	Heart pacemaker	<input type="checkbox"/> <input type="checkbox"/>		
Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/>	Heart trouble/Disease	<input type="checkbox"/> <input type="checkbox"/>		
<b>Date :</b> _____		Hayfever	<input type="checkbox"/> <input type="checkbox"/>		
Anemia / Blood Disorder	<input type="checkbox"/> <input type="checkbox"/>	Herpes	<input type="checkbox"/> <input type="checkbox"/>		
Asthma / Respiratory Disorder	<input type="checkbox"/> <input type="checkbox"/>	High Cholesterol	<input type="checkbox"/> <input type="checkbox"/>		
Artificial Heart Valve / Heart Bypass	<input type="checkbox"/> <input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/> <input type="checkbox"/>		
<b>Date :</b> _____		Insomnia / Frequent waking	<input type="checkbox"/> <input type="checkbox"/>		
Alzheimer's Disease	<input type="checkbox"/> <input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/> <input type="checkbox"/>		
Arthritis/Gout	<input type="checkbox"/> <input type="checkbox"/>	Kidney problems	<input type="checkbox"/> <input type="checkbox"/>		
Bell's Palsy	<input type="checkbox"/> <input type="checkbox"/>	Liver Disease / Jaundice	<input type="checkbox"/> <input type="checkbox"/>		
Bleeding Problems	<input type="checkbox"/> <input type="checkbox"/>	Leukemia	<input type="checkbox"/> <input type="checkbox"/>		
Blood Pressure <input type="checkbox"/> High <input type="checkbox"/> Low	<input type="checkbox"/> <input type="checkbox"/>	Lung Disease	<input type="checkbox"/> <input type="checkbox"/>		
Cancer	<input type="checkbox"/> <input type="checkbox"/>	Neurological Disorders	<input type="checkbox"/> <input type="checkbox"/>		
<b>Type :</b> _____ <b>Date :</b> _____		Psychiatric / Psychological	<input type="checkbox"/> <input type="checkbox"/>		
Chemotherapy	<input type="checkbox"/> <input type="checkbox"/>	Posture Problems	<input type="checkbox"/> <input type="checkbox"/>		
Radiation	<input type="checkbox"/> <input type="checkbox"/>	Stroke	<input type="checkbox"/> <input type="checkbox"/>		
Congenital Heart Disease	<input type="checkbox"/> <input type="checkbox"/>	<b>Date :</b> _____			
Convulsions	<input type="checkbox"/> <input type="checkbox"/>	Stents	<input type="checkbox"/> <input type="checkbox"/>		
		<b>Date :</b> _____			

**ALLERGIES TO ANY MEDICATIONS**

Penicillin    Latex    Codeine    Metals    Sulfa    Food    Aspirin    Local Anesthetics

List Other Allergies

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

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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:

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