New Patient Registration

About you

Date: _____

Name: _____ _____ _____ _____
Title Last First Mid

What would you prefer to be called _____

Sex: ☐ Male ☐ Female Age : _____

Home address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Home phone #: (___) - ___ - ____ Cell Phone #: (___) - ___ - ____

Work Phone #: (___) - ___ - ____ Ext: ____

Email address: _____

Do you have Dental Insurance? ☐ Yes ☐ No

Marital status: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed

Employer: _____

Subscriber : _____

Insurance Company : _____

Subscriber's SSN : ____-____-____ Birthday : ___/___/____

Where & when are best times to reach you? _____

How did you hear about us? _____

Whom may we thank for this referral? _____

Other family members seen by us: _____

_____

_____

_____

_____

Who is financially responsible for this account? _____

Previous dentist: _____

Nearest Relative Not Living with You

His / Her name: _____

Relationship: _____

Home Phone #: (___) - ___ - ____

Work Phone #: (___) - ___ - ____ Ext: ____

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Telephone home: (___) - ___ - ____ Date of last visit: ___/___/____

Your current physical health is: ☐ **Good** ☐ **Fair** ☐ **Poor**

Are you presently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

_____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription or over-the-counter drugs? ☐ Yes ☐ No

Please explain: _____

_____

Do you get cold sores? ☐ Yes ☐ No

Do you wear a cardiac pacemaker, or have you had heart surgery? ☐ Yes ☐ No
When? ___/___/____

Are you required to take any medication before your dental visit? ☐ Yes ☐ No
What? _____

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems

Yes / No			Yes / No	
☐	☐	Rheumatic Fever	☐	☐	Cancer
☐	☐	Thyroid Disease	☐	☐	Seizure Disorder
☐	☐	Heart Disease	☐	☐	Aids/HIV
☐	☐	Anemia	☐	☐	Artificial Joint / Heart Valve
☐	☐	Kidney Disease	☐	☐	Hepatitis Type: ☐ A ☐ B ☐ C
☐	☐	Heart Murmur (or MVP)	☐	☐	Eating Disorders
☐	☐	Asthma	☐	☐	History of Endocarditis
☐	☐	Venereal Disease	☐	☐	Radiation Therapy: Head / Neck
☐	☐	High Blood Pressure	☐	☐	Alcohol and Drug Abuse
☐	☐	Diabetes	☐	☐	Arthritis
☐	☐	Bleeding Problems	☐	☐	Liver Disease
☐	☐	Tuberculosis	☐	☐	Psychiatric Treatment
☐	☐	Are you nursing			

Please list any serious medical condition(s) that you have ever had:

_____

_____

Medical History (Continued)

Are you allergic to any of the following?

☐ Yes	☐ No	Aspirin	☐ Yes	☐ No	Erythromycin
☐ Yes	☐ No	Penicillin	☐ Yes	☐ No	Sulfa drugs
☐ Yes	☐ No	Jewelry / Metals	☐ Yes	☐ No	Codeine
☐ Yes	☐ No	Anesthetic (Novocain, etc.)	☐ Yes	☐ No	Tetracycline
☐ Yes	☐ No	Latex	☐ Yes	☐ No	Other

Please list any other drugs/ Materials that you are allergic to :

Are You Now Taking:

Drugs for high blood pressure?	☐ Yes	☐ No	Drugs for sleep?	☐ Yes	☐ No
Cortisone, steroids or ACTH?	☐ Yes	☐ No	Insulin?	☐ Yes	☐ No
Tranquilizers or sedatives?	☐ Yes	☐ No	Antibiotics?	☐ Yes	☐ No
Anticoagulants or blood thinner?	☐ Yes	☐ No			

Please list any medications you are currently taking?

Dental Health and Appearance

Reason for visit :

Approximate date of last dental visit : __/__/____

What is your primary concern that you would like us to address first?

When would you like us to start treatments?

Have you ever had any serious problem associated with previous dental treatment or any dental emergencies? ☐ Yes ☐ No

If so, Please Explain :

What, if anything, has happened in previous experiences at the dentist that was reason not to return?

Do you ever feel (or have you ever been told) that you don't have fresh breath? ☐ Yes ☐ No

How often do you brush your teeth? _____ time(s) a _____

How often do you floss? _____ time(s) a _____

What type of brush do you use? ☐ Manual ☐ Powered

Do you avoid brushing any part of your mouth because of pain? ☐ Yes ☐ No

If Yes, What part?

Which foods cause you twinges of pain :
☐ Hot ☐ Cold ☐ Sweet ☐ Sour ☐ None

Dental Health and Appearance(Continued)

Do your gums feel tender or swollen? ☐ Yes ☐ No

Do you chew on only one side of your mouth? ☐ Yes ☐ No

If so, Please Explain :

Do you clench or girnd your jaws while sleeping or during the day? ☐ Yes ☐ No

Do your jaws ever feel tired? ☐ Yes ☐ No

Are you delighted with your smile? ☐ Yes ☐ No

Please rate your smile from 1 to 10 (1=I hate my smile, 10=Awesome) : _____

Would you like to have whiter teeth? ☐ Yes ☐ No

If you had a magic wand, what, if anything, would you charge about your smile :

What (if any) personal or professional benefit might you gain if you had a gorgeous smile?

Do you have any special occastions coming up?

☐ **I Understand That Payment Is Due At Time of Service.**
I will pay today by:
☐ CASH ☐ CHECK ☐ CREDIT CARD ☐ CARE CREDIT

☐ I verify that the preceding information is true. I authorize the release of information to the insurance company. I will allow Dr. David Spilkia, DMD and his associates to discuss the conditions with my physician(s) and to request medical information from them. I authorize the office of David Spilkia, DMD to obtain and verify a credit report.

☐ The information and health history and preceding answers are true and correct to the best of my knowledge. I authorize and give consent to perform dental services agreed between doctor and patient and/or guardian to be necessary or advisable, including the use of local anesthesia and other medications as indicated. I agree that, regardless of insurance coverage, I am responsible for payment for services rendered. If I ever have any changes in my health or if my medication change I will, without fail, inform the doctor at my next appointment.

Signature: _____ Date: _____

OFFICE USE ONLY

(Year 1) Initials:_____ Date:_____

(Year 2) Initials:_____ Date:_____

(Year 3) Initials:_____ Date:_____

Year 2: Changes in health _____

Date: _____ Signature_____

Year 3: Changes in health _____

Date: _____ Signature_____

Health questionnaire must be updated each year