

New Patient Registration

ABOUT YOU

First name	Middle initial	Last name	
Street address	City	State	ZIP code
Date of birth	Sex	Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	
Home phone	Cell phone	Work phone	
May we call you at work? ☐ Yes ☐ No		Social Security # (only if needed for insurance)	
Email address		Paperless billing statements by email? ☐ Yes ☐ No	
Employer / occupation		Employer phone	
Emergency contact		Emergency contact phone	
Your general dentist	Dentist phone	Who referred you to our office?	

DENTAL INSURANCE

Name of insured person (policyholder)		Relationship to patient
Policyholder date of birth	Policyholder SSN	Insured ID #
Policyholder employer	Group #	
Insurance company	Insurance company address	Insurance phone
Do you have a second (secondary) insurance? ☐ Yes ☐ No If yes, please complete:		
Secondary insurance company		Group #
Name of insured person (policyholder)		Relationship to patient
Policyholder date of birth	Policyholder SSN	Insurance phone

RESPONSIBLE PARTY (IF PATIENT IS UNDER 18 OR A FULL-TIME STUDENT)

First name	Middle initial	Last name	
Address	City	State	ZIP
Home phone	Work phone	Date of birth	

Please complete the medical history on the back. →

Medical History

These questions help us diagnose and treat you safely. Your answers are confidential. Please let us know whenever your health or medicines change.

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Has your health changed in the past year?
If yes, please explain: | ☐ | ☐ |
| 2. Are you in good health?
If not, please explain: | ☐ | ☐ |
| 3. Are you taking any medicines or drugs?
Please list all: | ☐ | ☐ |
| 4. Do you have any allergies to foods, medicines, latex or metals?
If yes, which ones? | ☐ | ☐ |

5. Do you have, or have you ever had, any of the following? (check all that apply)

- | | |
|--|---|
| ☐ High blood pressure | ☐ Sinus trouble |
| ☐ Heart murmur or mitral valve prolapse (MVP) | ☐ Thyroid problems |
| ☐ Joint prosthesis / replacement | ☐ Diabetes |
| ☐ Rheumatic fever or rheumatic heart disease | ☐ Stomach ulcers or irritable bowel syndrome |
| ☐ Congenital heart disease | ☐ Colitis |
| ☐ Prosthetic heart valve | ☐ Hepatitis, jaundice or liver disease |
| ☐ Blood disorder (such as anemia) | ☐ Psychiatric treatment |
| ☐ Sexually transmitted infection (STI) | ☐ Epilepsy, fainting spells or seizures |
| ☐ Asthma | ☐ Cancer |
| ☐ TMJ (jaw joint) problems | ☐ HIV/AIDS |

Have you been told to take antibiotics before dental treatment (premedicate)? ☐ Yes ☐ No

6. Do you have a pacemaker and/or defibrillator? ☐ Yes ☐ No

7. Do you have any other disease, condition or problem not listed above? ☐ Yes ☐ No

8. Women: Are you pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

9. Do you take birth control pills? ☐ Yes ☐ No

Antibiotics can make birth control pills less effective. If you take them, please use a backup method of birth control while you are on antibiotics.

I understand that, as a service to me, the office will help process my insurance claims, but **I am fully responsible for all fees.** All of the information above is true to the best of my knowledge.

Signature (patient, or parent if patient is a minor)

Date

I give Dr. Warren permission to use my x-rays and/or photographs in seminars or publications.

Signature (patient, or parent if patient is a minor)

Date