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NATOMAS DENTAL
Service with a smile ☺ for a smile ☺

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NEW PATIENT REGISTRATION FORM

The following information is necessary and will be CONFIDENTIAL Today's date: ____/___/_____

PATIENT INFORMATION

Name: _____ Social Security #: _____-____-_____
Residential Address: _____
City Zip
Sex: ☐ M ☐ F Age _____ Birthday: ___/___/____ Patient's: Res. # (_____)_____ -_____
Is the patient ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
If patient is a minor, please provide the name of legal guardian:_____
Patient/Guardian's Driver's License #: _____ Relationship to the patient: _____

INSURED PERSON'S INFORMATION

Name of Employer: _____ Occupation:_____
Business Address: _____ _____ _____ Bus. #: (____)____-_____
Street City Zip

Name of Insurance Co.: _____ _____ _____ _____
(Primary Insurance Co.) Birthdate Relationship Social Security #

Name of Insurance Co.: _____ _____ _____ _____
(Secondary Insurance Co.) Birhtdate Relationship Social Security #

_____ _____ _____ _____ _____
Name of Group Dental Plan Group No. Plan No. Name of Union Local

DENTAL HISTORY

1. What would the patient (here-in after referred to as you) like to discuss with the dentist today?
   ☐ Routine Checkup ☐ Second Opinion ☐ Tooth Ache ☐ Gum Problems
   ☐ Oral Surgery ☐ Replacement of missing teeth ☐ Cosmetic Dentistry ☐ Braces
   ☐ Crowns/Bridge ☐ Removal of Wisdom Teeth ☐ Partial/Full Dentures ☐ Others _____
2. Are you pleased with the appearance of your Smile ☺? ☐ Yes/ ☐ No
   If no, please explain _____
3. When did you last visit the dentist ? _____/_____/_____.
4. When were your dental X-rays last taken ? _____/_____/_____
5. When was the last teeth cleaning performed on your teeth by a dentist ? _____/_____/_____.
6. What treatment was performed by your last dentist ? _____.
7. Was the treatment completed ? ……☐ Yes/ ☐ No
8. Have you had any problems with past dental treatment ? ☐ Yes/ ☐ No, If yes, please specify _____
   _____.
9. Have you ever had prolonged bleeding after extraction(s) ? …☐ Yes/ ☐ No
10. Are your teeth sensitive to hot or cold ?……☐ Yes/ ☐ No
11. Do your gums bleed easily ?……..☐ Yes/ ☐ No
12. Do you feel you have bad breath ? ……☐ Yes/ ☐ No
13. Does your Jaw pop or click when chewing (TMJ)? ☐ Yes/ ☐ No…..If yes, which side(s) _____
14. Do you have any missing teeth? ☐ Yes/ ☐ No If yes, do you have any appliances? ☐ Yes/ ☐ No
    What type is it? _____ Year the appliance was made? _____, Is it comfortable? ☐Yes/ ☐ No
15. Can you please tell how you heard about us ?_____,
    If referred, would you please tell us whom we should thank for your visit ? _____.

Patient/Gaurdian initials: _____

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MEDICAL HISTORY

The following questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

Name of Physician: _____ _____ _____ (___)____-____
Address City Zip Telephone

1. Are you in good health ? ☐ Yes/ ☐ No Date of last Physical examination _____
2. Are you now under the care of a Physician ? ☐Yes/ ☐ No;
   If so, for what condition(s) ? _____
3. Have you ever had any serious illness or operation? ☐ Yes/ ☐ No
   If so, what illness or operation ? _____
4. Have you ever been Hospitalized ? ☐ Yes / ☐No; If so, what was the problem ? _____
5. Are you taking any medicine ? ☐ Yes / ☐No; If so, What ? _____ What dosage ? _____
6. Are you taking any recreational drugs ? ☐Yes / ☐ No; Which one(s) ?_____
7. Have you ever been premedicated with antibiotics for your dental treatment ? …… ☐ Yes/ ☐ No
8. Are you sensitive or allergic to any drugs ? …☐Yes / ☐ No ☐ Penicillin, ☐ Tetracycline, ☐ Sulfa Drugs, ☐ Aspirin, ☐ Codeine If other, what drug ? _____,
9. Have you ever used Phen Phen ?… ☐ Yes/ ☐ No Are you allergic to latex gloves ? … ☐ Yes/ ☐ No
   Are you allergic to Local Anesthesia ? …….. ☐ Yes /☐ No

10. Do you have or have you had any of the following: [Please check (X) known conditions]

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Acquired Immune Deficiency Syndrome	☐	☐	Congenital Heart Lesions	☐	☐	Herpes	☐	☐	Shortness of Breath
☐	☐	Aids Related Complex	☐	☐	Diabetes	☐	☐	High Blood Pressure	☐	☐	Skin Rash
☐	☐	Allergies or Hives	☐	☐	Difficulty in Swallowing	☐	☐	HIV Positive	☐	☐	Sinus Trouble
☐	☐	Anemia	☐	☐	Epilepsy or Seizures	☐	☐	Jaw Pain	☐	☐	Special Diet
☐	☐	Artificial Prosthesis	☐	☐	Excessive Bleeding	☐	☐	Joint Replacement	☐	☐	Stomach Ulcers
☐	☐	Arthritis	☐	☐	Fainting Spells	☐	☐	Kidney Disease	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Glaucoma	☐	☐	Liver Disease	☐	☐	Swollen Neck Glands
☐	☐	Back Problems	☐	☐	Hay Fever	☐	☐	Nervous Problems	☐	☐	Swollen Ankles/Feet
☐	☐	Blood Disease	☐	☐	Headaches	☐	☐	Pain in Joints	☐	☐	Thyroid Disease
☐	☐	Blood Transfusion	☐	☐	Head Injuries	☐	☐	Psychiatric Care	☐	☐	Tonsillitis
☐	☐	Cancer	☐	☐	Heart Murmur	☐	☐	Radiation Treatment(any)	☐	☐	Tumors or Growth
☐	☐	Cerebral Palsy	☐	☐	Heart Problems	☐	☐	Respiratory Disease	☐	☐	Tuberculosis (TB)
☐	☐	Chemical Dependency	Describe: _____			☐	☐	Rheumatism	☐	☐	Ulcers
☐	☐	Chicken Pox	☐	☐	Hemophilia	☐	☐	Rheumatic Fever	☐	☐	X-Ray/Cobalt Treatment
☐	☐	Circulatory Problems	☐	☐	Hepatitis or Jaundice	☐	☐	Scarlet Fever	☐	☐	Venereal Disease (syphilis/Gonorrhea)
☐	☐	Cold Sores							☐	Others _____	

11. Do you wear a cardiac pacemaker, or have you had heart surgery? ☐ Yes/ ☐ No
12. Do you have any disease, condition or problem not listed that you think I should know about? ☐ Yes/ ☐ No,
    If so what ? _____
13. (**Woman Only**) Are you pregnant ? ☐ Yes/ ☐ No, If yes, how many months ? _____

AUTHORIZATION

I have filled out this health questionnaire completely and advised you of all medical problems of which I am aware. I understand that I am personally responsible for the cost of my dental care. I agree to pay for any work rendered by this office. if for any reason whatsoever my insurance coverage denies liability/payment to the dentist. I will notify this office of any change in eligibility for insurance coverage. If in default of the above agreement on my part necessitates legal action, I shall assume all responsibility for interest, principal and reasonable attorney's fees.

SIGNATURE OF PATIENT/GUARDIAN: _____ **DATE**: ____/____/____

My dental treatment and possible alternatives have been discussed with me. I have been informed of all risks involved with my dental care and local anesthesia, including possible blood loss and infection. I hereby consent to the administration of local anesthesia and the dental treatments specified by the diagnosing doctor.

_____ _____ _____ _____
Signature of Doctor Date Signature of Patient/Guardian Date