Center for Esthetic Dentistry, LLC
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NEW PATIENT REGISTRATION

Last Name: _____ First Name: _____

Name you like to be called: _____Today's Date: _____

Home Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Driver's License # _____ SS#: _____ DOB: _____/_____/_____ Age: _____

Marital Status: _____ Sex: _____ Children: _____

Employer: _____Work Phone: _____

Employer Address: _____

Emergency Contact Person and Address: _____

Relationship: _____ Phone: _____

How did you find us? _____

Who can we thank for referring you here? _____

PRIMARY DENTAL BENEFIT COVERAGE

Insured Name: _____ Relationship to Patient: _____

SS#: _____ DOB: _____/_____/_____ Group #: _____ ID #: _____

Employer Name and Address: _____

Insurance Co. Name and Address: _____

MEDICAL ALERTS

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING MEDICATIONS?

(Please circle)

Aspirin	Local Anesthetic	Erythromycin	Codeine
Penicillin	Latex (gloves, balloons)	Novocaine	Ibuprofen

Are you aware of any allergies to any other medications and substances? _____
If so, please list them: _____
Do you have any skin reaction from wearing jewelry? _____, what kind? _____

PAST DENTAL / MEDICAL HISTORY

How long has it been since you have seen a dentist? _____

When was your last exam and x-ray? _____

Who was your previous dentist? _____ City: _____

What brings you here today? Please tell us about it:

_____

_____

_____

Do you have any current health problems? _____

Are you under a physicians care? _____

Who is your physician: _____ Phone #: _____

What medications are you currently taking? _____

Are you pregnant? Y N Due: _____ Do you smoke? Y N # / Day _____

Have you ever had gastric bypass or similar surgery? Y N

Please check off any of the following which you have had, or presently have:

- o Heart disease / attack
- o Angina Pectoris
- o High blood pressure
- o Heart Murmur
- o Rheumatic Fever
- o Congenital Heart Lesions
- o Mitral Valve Prolapse
- o Artificial Heart Valve
- o Heart Pacemaker
- o Heart Surgery
- o Artificial Joints (hip and knee)
- o Anemia
- o Stroke
- o Kidney Trouble
- o Ulcers
- o AIDS/ARC/HIV Pos.
- o Hepatitis A (infectious)
- o Hepatitis B (serum)
- o Hepatitis C
- o Liver Disease
- o Blood Transfusion
- o Drug Addiction
- o Hemophilia (bleeding problems)
- o Epilepsy / Seizures
- o Nervousness
- o Psychiatric Treatment
- o Glaucoma
- o Chemotherapy (cancer, leukemia)
- o Venereal Disease (syphilis, gonorrhea, etc.)
- o Bruise Easily
- o Emphysema
- o Tuberculosis (TB)
- o Asthma
- o Hay Fever
- o Sinus Trouble
- o Allergies/Hives
- o Diabetes
- o Thyroid Disease
- o Radiation Treatment
- o Arthritis
- o Cortisone Medicine
- o Pain in Jaw Joints
- o Alcoholism
- o Cosmetic Surgery

I have NOT had any of the above illnesses or diseases _____ (initial)

SMILE / ORAL HEALTH HISTORY

This will give us the best idea of what you are looking for.
We are committed that every patient gets the best possible treatment when they are here.

Please rank the following in the order in which they would keep you from having any dental treatment.
#1 being the most likely and #4 being the least likely:

Fear of pain # Lack of concern #
Cost of treatment # Missing work time #

How would you rate your dental health	*(Excellent)*	1	2	3	4	5	*(Poor)*
How would you rate your dental home care?		1	2	3	4	5	
How do you feel about your smile?		1	2	3	4	5	
How would you rate your apprehensiveness	*(Not at all)*	1	2	3	4	5	*(Very)*

How many times a day do you brush? _____ How long do you take? _____

What technique do you use?_____

Do you floss? Y N Do your gums bleed? Y N With flossing? Y N

Any hot/cold/sweet sensitivity? Y N Where _____

Do you grind or clench? Y N When_____

Do you get headaches? Y N Tell us about them: _____

Have you worn braces? Y N When and for how long? _____

How do you feel about the color of your teeth? _____

If you could change anything about your smile without holding back, what would you change?

_____

_____

_____

If there is anything that we need to know about you or your dental past to serve you better, please let us know.
Use the space below to describe any dental fears or phobias.

_____

_____

_____

Thank you for taking the time to fill this out. We look forward to serving you.

Signature _____ Date _____

Dr. / Staff Signature _____ Date _____