# IRVING FAMILY DENTAL

## New Patient Registration Form

**PATIENT LAST NAME:** _____ **FIRST:** _____ **INITIAL:** _____

How do you wish to be addressed? _____ DOB _____

(❑ Single ❑ Married ❑ Divorced) (❑ Male ❑ Female) Full time Student? ❑ Yes ❑ No School _____

Address _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____

Soc. Sec. No. _____ Dental Insurance Co. _____ Group _____

Is patient covered by another dental insurance? ❑ Yes ❑ No Insurance Co. _____

How did you hear about our practice? Whom may we thank for your referral? _____

### HUSBAND, FATHER OR RESPONSIBLE PARTY (IF OTHER THAN PARENT)

Last Name _____ First _____ Initial _____

Address _____ DOB _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____

Soc. Sec. No. _____ Dental Insurance Co. _____ Group _____

### WIFE, MOTHER OR RESPONSIBLE PARTY (IF OTHER THAN PARENT)

Last Name _____ First _____ Initial _____

Address _____ DOB _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____

Soc. Sec. No. _____ Dental Insurance Co. _____ Group _____

### NEAREST RELATIVE

Last Name _____ First _____ Initial _____

Address _____

City _____ State _____ Zip _____ E-Mail _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

### AUTHORIZATION

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits **may pay less** than the actual bill for services. I understand **I am financially responsible** for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer.

I attest to the accuracy of the information on this page.

Signature _____ Date _____

# IRVING FAMILY DENTAL

## Adult Medical History

Patient Name_____ D O B _____

Emergency Contact (Name/Phone Number) _____

## Medical History

1 Physician_____ Address_____

2 When was your last physical examination? _____

3 Are you under the care of a physician? ☐ Y ☐ N

If yes, for what reason(s)? _____

4. Are you presently taking any medications/drugs/pills/herbals/supplements? ☐ Y ☐ N

If yes, please list:_____

5. (Women) Is there a chance you are pregnant? ☐ Y ☐ N

If yes, anticipated due date?_____

6. Do you take oral contraceptives? ☐ Y ☐ N

7. Are you allergic/sensitive to: (circle) None Codeine Penicillin Local Anesthetic Latex Dyes

☐ Other_____

8 Do you smoke, chew or use E-cigarettes ☐ Y ☐ N

If yes, please indicate which one(s), daily frequency and how long?_____

9 Do you have Diabetes? ☐ Y ☐ N

If yes, please indicate ☐ Type 1 ☐ Type 2 Last HbA1c date and level_____

10. Do you have, or have you ever had:

| | Y | N |
|---|---|---|
| Heart trouble | ☐ | ☐ |
| Heart murmur | ☐ | ☐ |
| Heart surgery | ☐ | ☐ |
| Heart pacemaker | ☐ | ☐ |
| Rheumatic fever | ☐ | ☐ |
| Congenital heart defects | ☐ | ☐ |
| Artificial heart valve/stent/graft | ☐ | ☐ |
| Abnormal blood pressure | ☐ | ☐ |
| Stroke | ☐ | ☐ |
| Ulcers /GERD | ☐ | ☐ |
| Kidneytrouble/Dialysis | ☐ | ☐ |
| Tuberculosis or lung disease | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Sinustrouble | ☐ | ☐ |
| Epilepsy / seizures | ☐ | ☐ |
| Fainting spells | ☐ | ☐ |
| Anemia | ☐ | ☐ |
| Leukemia | ☐ | ☐ |

| | Y | N |
|---|---|---|
| Excessive or prolonged bleeding | ☐ | ☐ |
| Thyroid problem | ☐ | ☐ |
| Jaundice | ☐ | ☐ |
| Hepatitis(Type) | ☐ | ☐ |
| Cancer | ☐ | ☐ |
| Chemotherapy/radiation | ☐ | ☐ |
| Arthritis | ☐ | ☐ |
| Artificial joint replacements | ☐ | ☐ |
| Cortico-Steroid treatment | ☐ | ☐ |
| Osteoporosis/treatment w/Bisphosphonates | ☐ | ☐ |
| HIV positive/AIDS | ☐ | ☐ |
| Oral herpetic lesions | ☐ | ☐ |
| Sexually Transmitted disease | ☐ | ☐ |
| Psychiatric care | ☐ | ☐ |
| Glaucoma | ☐ | ☐ |
| Hearing impaired | ☐ | ☐ |
| Chemical dependency | ☐ | ☐ |
| Do you take pre-medication for anything | ☐ | ☐ |

If you pre-medicate, for what _____

11. Have you had any other serious illness, hospitalization or accident? ☐ Y ☐ N

If yes, please explain:_____

# IRVING FAMILY DENTAL

## Dental History

1. Former Dentist_____ Address _____

2. When did you last visit a dentist?_____ When was your last cleaning? _____

   X-rays taken? ☐ Y ☐ N

   If yes ☐ Full Mouth Series ☐ Bitewings ☐ Panoramic

   What was done at your last visit? _____

3. Any dental problems or concerns?

   Explain: _____

4. Have you ever been treated for gum disease? ☐ Y ☐ N

5. Is your water fluoridated? ☐ Y ☐ N

6. Are your teeth sensitive to: ☐ Nothing ☐ Sweet ☐ Cold ☐ Heat ☐ Pressure

7. Would you like a whiter smile? ☐ Y ☐ N

8. Would you like straighter teeth? ☐ Y ☐ N

9. Have you had your teeth straightened/ worn braces? ☐ Y ☐ N

10. Are you concerned with bad breath (malodor)? ☐ Y ☐ N

11. Are you concerned with snoring or sleep apnea? ☐ Y ☐ N

12. Are you concerned with grinding or clenching your teeth (bruxism)? ☐ Y ☐ N

    Do you wear a bite guard? ☐ Y ☐ N

13. Are you aware of possible TMJ problems - does your jaw joint make noise, lock up or create pain? ☐ Y ☐ N

14. Are you interested in sleep/sedation dentistry? ☐ Y ☐ N

15. Is there anything else that would be valuable for your dentist to know to best care for you? _____

- **I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care**
- **I authorize the release of any information concerning my (or my child's) healthcare, advice, and treatment to another dentist**
- **I have accurately advised my dental care provider of my current health status and any dietary or herbal supplements, medications and/or drugs (including recreational and over the counter) that I am taking or have taken in the last week**

Patient Signature_____ Date _____

(Parent/Guardian)

Dentist Signature_____ Date _____

Medical Clearance needed: Yes No Dentist's Signature:_____Date_____

Medical Clearance Received: Yes No Dentist's Signature:_____Date_____

Medical Clearance Reviewed: Yes No Dentist's Signature:_____Date_____