NEW PATIENT REGISTRATION

Patient: _____
Last Name First Name MI Preferred Name

Address: _____ City _____ State _____ Zip _____

SSN: _____ DOB: _____ ☐ Male ☐ Female

Home Phone: _____ Work Phone:_____

Cell Phone:_____ Email Address:_____

Employer:_____ Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

How did you hear about our office?_____

Insurance

Subscriber Name:_____ Relationship to Patient:_____ Subscriber DOB:_____

Subscriber SSN/ID: _____ Subscriber Employer:_____

Insurance Company Name:_____

Insurance Company Address:_____

Insurance Company Phone:_____ ID Number:_____ Group Number: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign all insurance benefits directly to Dalia Tadros, D.D.S., P.A. I understand that I am financially responsible for the charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature on all insurance submissions. Also, I will respect the doctor/hygienist's schedule and give at least 2 days' notice when I need to change my appointment.

Responsible Party Signature: _____

Relationship:_____ Date:_____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: _____

NEW PATIENT MEDICAL HISTORY

Physician's Name: _____

Physician's Phone:_____ Date of last visit:_____

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

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

Please explain: _____

Do you use tobacco in any form? ☐ Yes ☐ No

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

Are you taking any medications? ☐ Yes ☐ No Please list each one: _____

Do you have drug allergies or have you ever had an adverse reaction to any medication/anesthesia? ☐ Yes ☐ No

If so, what? _____

Have you ever had any surgical procedures? ☐ Yes ☐ No Please list each one: _____

Are you taking birth control pills? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No If so, how many weeks? _____

Do any of the following apply:

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
□	□	Abnormal Bleeding	□	□	Diabetes	□	□	Heart Surgery	□	□	Psychiatric Problems
□	□	Alcohol Abuse	□	□	Difficulty Breathing	□	□	Hemophilia	□	□	Radiation Therapy
□	□	Allergies	□	□	Drug Abuse	□	□	Hepatitis A	□	□	Rheumatic Fever
□	□	Anemia	□	□	Emphysema	□	□	Hepatitis B	□	□	Seizures
□	□	Angina Pectoris	□	□	Epilepsy	□	□	Hepatitis C	□	□	STDs
□	□	Arthritis	□	□	Facial Surgery	□	□	High Blood Pressure	□	□	Shingles
□	□	Artificial Heart Valve	□	□	Fainting Spells	□	□	Joint Replacement	□	□	Sickle Cell Disease
□	□	Asthma	□	□	Fever Blisters	□	□	Kidney Problems	□	□	Sinus Problems
□	□	Blood Transfusion	□	□	Frequent Headaches	□	□	Liver Disease	□	□	Stroke
□	□	Cancer	□	□	Glaucoma	□	□	Low Blood Pressure	□	□	Thyroid Problems
□	□	Chemotherapy	□	□	HIV + AIDS	□	□	Mitral Valve Prolapse	□	□	Tuberculosis
□	□	Colitis	□	□	Heart Attack	□	□	Pace Maker	□	□	Ulcers
□	□	Congenital Heart Disease	□	□	Heart Murmur						

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____ _____

Patient's Signature Date

NEW PATIENT DENTAL HISTORY

HOW LONG SINCE you have seen a dentist?

Date of your last COMPLETE dental exam?

Date of your last FULL MOUTH X-RAYS?

Are you currently having PAIN or PROBLEMS? ☐ Yes ☐ No

If so, please describe:

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you wear DENTURES? ☐ Yes ☐ No

If so, circle one: PARTIALS or FULL Are you UNHAPPY with your dentures? ☐ Yes ☐ No

Would you like to learn more about PERMANENT REPLACEMENT? ☐ Yes ☐ No

Are you APPREHENSIVE about dental treatment? ☐ Yes ☐ No

Have you had any PERIODONTAL (GUM) treatment? ☐ Yes ☐ No

Do your gums BLEED, or feel TENDER or IRRITATED? ☐ Yes ☐ No

Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle one) ☐ Yes ☐ No

Are you UNHAPPY with the APPEARANCE of your teeth? ☐ Yes ☐ No

Are you aware of GRINDING or CLENCHING your teeth? ☐ Yes ☐ No

Do you have HEADACHES, EARACHES, or NECK PAINS? ☐ Yes ☐ No

Have you worn BRACES on your teeth (ORTHODONTICS)? ☐ Yes ☐ No

Do you have DISCOLORED teeth that bother you? ☐ Yes ☐ No

Would you like your smile to look BETTER or DIFFERENT? ☐ Yes ☐ No

Do you REGULARLY use DENTAL FLOSS? ☐ Yes ☐ No

Name of previous dentist? City/State:

How do you feel about your teeth?

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment:

FEAR of pain	#	LACK of concern	#
COST of treatment	#	MISSING work time	#