LAUREL SMILES
DENTAL CARE

New Patient Registration Form

Patient Name	Social Security Number	Date of Birth
Home Address	City, State, Zip	Home Phone
Cell Phone	Email Address	Work Phone
Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated	❑M ❑F	Drivers License and State

Primary Insurance Company _____Group_____Subscriber_____

Secondary Insurance Company _____Group_____Subscriber_____

Responsible Party (If Different than Above)

Name	Social Security Number	Date of Birth
Home Address	City, State, Zip	Home Phone
Cell Phone	Email Address	Driver's License and State
Relationship	Employer	Employer Address

Patient's Dental Health History

Why have you come in to see us today? (e.g pain, checkup, cosmetics etc.)_____

Previous Dentist_____Last Visit_____Date of last Cleaning_____

Reason for changing dentist _____

How often do you see a dentist?

❑ every 3 months ❑ every 6 months ❑ once a year ❑ not routinely

Any Complications with past dental treatment?_____

How often do you Brush?_____Do You Floss? ❑ Yes (How Often_____) ❑ No

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Please answer the following questions about your oral health ? (please circle each)

Y N My gums bleed when I brush or Floss.
Y N I avoid brushing part of my mouth due to pain.
Y N I have trouble eating
Y N I clench or grind my teeth during day or while sleeping.
Y N I have pain or sensitivity in my teeth or gums.
Y N I feel a hole in my tooth OR I have a broken tooth.
Y N I want my teeth whiter.
Y N I would like to get my teeth straight.
Y N I wake up multiple times at night and/or do not feel rested in the morning.
Y N I had orthodontic treatment done.

What are your priorities?_____
(e.g Dental Health, Appearance, Financial considerations, Time/Schedule etc.)

Patient's Medical History

Are you allergic to any of the following ? (Please circle Y for Yes or N for No)

Y N Aspirin
Y N Ibuprofen
Y N Sulfa Drugs/Sulfides
Y N Penicillin
Y N Codeine
Y N Erythromycin
Y N Latex
Y N Local Anesthetic (Novacaine)
Y N Metals
Y N Plastics
Y N Sedatives/ Sleeping Pills
Y N Barbiturates

Other Allergies not listed above_____

I consider my health to be (Please check one) ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Medications that I am currently taking (circle Y for yes or N for No)

Y N Antibiotics
Y N Insulin
Y N Anticoagulants
Y N Muscle Relaxants
Y N Barbiturates
Y N Aspirin
Y N Blood Thinners
Y N Pain Medication
Y N Codeine
Y N Sleeping Pills
Y N High Blood Pressure medication
Y N Others_____
Y N Cortisone
Y N Sulfa Drugs
Y N Diet Pills
Y N Ginko Biloba
Y N Heart Medication
Y N Tranquilizers
Y N Medications for osteoporosis
Y N Bisphosphonates
Y N Herbal Supplements
Y N Diabetes Medication

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Do you or have you had any of the following? (please circle Y for yes and N for no)

Y N Heart Disease
Y N Heart Murmur
Y N Mitral Valve Prolapse
Y N Stroke
Y N Congenital Heart Lesions
Y N Rheumatic Fever
Y N Anemia
Y N High Blood Pressure
Y N Asthma
Y N Epilepsy/Seizures
Y N Hay Fever
Y N Artificial Joints
Y N Immune Suppressed Disorder
Y N AIDS
Y N Glaucoma

Y N Liver Disease
Y N Jaundice
Y N Hepatitis Type_____.
Y N Diabetes Type_____.
Y N Herpes
Y N Arthritis
Y N Infectious Mononucleosis (Mono).
Y N Sexually Transmitted Disease
Y N Kidney Disease
Y N Tumor or Malignancy
Y N Cancer/Chemotherapy
Y N History of Drug Addiction
Y N Hearing Loss
Y N Fainting
Y N Nervous Disorders

Y N I usually take an antibiotic prior to dental treatment.
Y N I Smoke or use tobacco. If yes, how much per day?_____ How many years?_____
Y N I have consumed alcohol in the last 24 hours.
Y N I have had major surgery. Year_____ Type of Surgery_____
Y N Have you ever taken Fen-Phen or Redux ?
Y N Have you taken Bis-Phosphonates ?

For women ?

Y N Are you or could you be pregnant or nursing ?
Y N Do you take Birth Control Pills ?

In the event of emergency please contact:
Name _____Phone Number_____Relationship_____
Name_____Phone Number_____Relationship_____

Health History Reviewed by

Doctor's Signatures Date

X_____ X_____

Patient's Signature Date

_X_____ X_____