New Patient Registration Form

1st Family Dental
www.1fd.org

Referral Source: ______________________________

Email: ______________________________ Preferred to be contacted by: ☐ e-mail ☐ phone
☐ Yes! Please send me appointment reminders via email

Our forms are printed on paper sourced from sustainable forests. Soon we will become a paperless practice!
*Help support our **Green Initiative** by providing your email address to receive statements and reminders digitally.*

SECTION I: Patient Information

First Name ____________ Last Name ____________ Preferred Name ____________

Home Address: ____________ City: ____________ State: ______ Zip Code: ________

Home Phone: (_____)__________ Work Phone: (_____)__________ Cell Phone: (_____)__________

Date of Birth: ____________ Soc. Sec. #: ____________

Marital Status: ☐ Minor ☐ Single ☐ Married/Partner ☐ Separated ☐ Divorced ☐ Widowed

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to specify

Race: ☐ African American ☐ Caucasian ☐ American Indian or Alaskan Native ☐ Asian Indian ☐ Other__________

Preferred Language: ☐ English ☐ Spanish ☐ Other, please specify __________

Employment Status: ☐ Employed ☐ Unemployed ☐ Student ☐ Retired ☐ Other/Not Applicable

Emergency Contact Name ____________ Phone (_____)__________ Relationship __________

Section II: Responsible Party Information

(If someone other than patient, and/or patient is under age 18)

Relationship to Patient: ☐ Self ☐ Spouse/Partner ☐ Parent ☐ Other: ____________

Name (Last, First): ______________________________

Address (Line 1): ____________ City: ____________ State:_____ Zip Code: ________

Date of Birth: ____/____/_____ Soc. Sec. # : ____________ StateID/License#: ____________

Home Phone: (_____)__________ Cell Phone: (_____)__________ Work Phone: (_____)__________

Section III: Insurance Information

Name of Insured: ____________ Insured's Soc. Sec. #: ____________ Insured's Date of Birth: ________

Employer: ____________ Employer Address: ____________

Insurance Provider: ____________ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: ________

Additional Insurance: Name of Insured: ____________ Insured's Soc. Sec. #: ____________

Insured's Date of Birth: ________ Employer: ____________ Employer Address: ____________

Insurance Provider: ____________ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: ________

Signature ______________________________ Date: ____________

1ST FAMILY DENTAL

Patient Medical History

1st Family Dental
www.1fd.org

Patient Name: ______________________ Date of Birth: ____________ Gender: ______ Age: _______

Preferred Pharmacy: ________________ Address: ______________________________ Zip code: _______

Although Dental personnel primarily treat the area in and around your mouth, your dental health can affect your overall health in many ways. Health problems you may have, or medications you may be taking, could have an important interrelationship with the dental treatment you may receive. Thank you for answering the following questions completely and accurately.

General Medical History

Are you under a physician's care now? ___ Yes ___ No If Yes, Please Explain: ____________________

Have you ever had a serious head/neck injury? ___ Yes ___ No If Yes, Please Explain: ____________________

Are you taking any medications/pills/drugs? ___ Yes ___ No If Yes, Please List: ____________________

Have you been hospitalized or had a major operation? ___ Yes ___ No If Yes, Please Explain: ____________________

Have you taken, or do you take, Phen-Fen or Redux? ___ Yes ___ No ____________________

Are you on a special diet? ___ Yes ___ No ____________________

Do you use tobacco products? ___ Yes ___ No For How Long, # packs/day: ____________________

Do you use controlled substances? ___ Yes ___ No ____________________

For Women: Are you: ___ Pregnant/Trying to get pregnant? ____Nursing? ____Taking contraceptives? ____________________

Are you Allergic to any of the following:

____ Aspirin ____ Penicillin ____ Codeine ____ Acrylic ____ Metal ____ Latex ____ Local Anesthetics _____ Other: ________________

Do you have, or have you ever had, any of the following conditions:

__AIDS/HIV Positive
__Alzheimer's Disease
__Anaphylaxis
__Anemia
__Angina
__Arthritis/Gout
__Artificial Heart Valve
__Asthma
__Blood Disease
__Blood Transfusion
__Breathing Problem
__Bruise Easily
__Cancer
__Chemotherapy
__Chest Pains
__Cold Sores/Fever Blisters
__Congenital Heart Disorder
__Convulsions
__Cortisone Medicine
__Diabetes
__Drug Addiction
__Emphysema
__Epilepsy or Seizures
__Excessive Bleeding
__Excessive Thirst
__Fainting Spells/Dizziness
__Frequent Cough
__Frequent Diarrhea
__Frequent Headaches
__Genital Herpes
__Glaucoma
__Hay Fever
__Heart Attack/Failure
__Heart Murmur
__Heart Pace Maker
__Hemophilia
__Hepatitis A
__Hepatitis B or C
__Herpes
__High Blood Pressure
__Hives or Rash
__Hypoglycemia
__Irregular Heartbeat
__Kidney Problems
__Leukemia
__Liver Disease
__Low Blood Pressure
__Lung Disease
__Mitral Valve Prolapse
__Parathyroid Disease
__Psychiatric Care
__Radiation Treatments
__Recent Weight Loss
__Renal Dialysis
__Rheumatic Fever
__Rheumatism
__Scarlet Fever
__Shingles
__Sickle Cell Disease
__Sinus Trouble
__Spina Bifida
__Stomach/Intestinal Disease
__Stroke
__Thyroid Disease
__Tonsillitis
__Tuberculosis
__Tumors or Growths
__Ulcers
__Venereal Disease
__Yellow Jaundice

Have you ever had a serious illness not listed above? If Yes, please explain: ____________________

General Health History Comments: ______________________________________

Dental History

When was your last dental exam? ________________ When were your last dental x-rays taken? ________________

How often do you brush? _______ Times daily How often do you floss? _______ Times daily Type of toothbrush: _____ Manual _____ Electric

Have you ever had braces/orthodontic treatment? ___ Yes ___ No If yes, please explain: ____________________

Have you ever been treated for periodontal disease? ___ Yes ___ No If yes, when? ____________________

Have you ever had injuries to your teeth, face or jaw? ___ Yes ___ No If yes, please explain: ____________________

Do you experience, or have you experienced in the past, any of the following:

__Bad Breath
__Dentures
__Ear Pain
__Sensitivity – Cold
__Bleeding Gums
__Dental Anxiety
__Jaw Pain
__Sensitivity – Hot
__Blisters on Mouth
__Difficulty Opening/Closing
__Loose Teeth
__Sensitivity – Sweets
__Broken Fillings/Teeth
__Difficulty Chewing
__Missing Teeth
__Sensitivity – Pressure
__Clicking Jaw
__Dry Mouth
__Mouth Sores
__Swollen Gums

To the best of my knowledge, the questions on this form have been answered completely and accurately. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform 1st Family Dental of any changes in medical status.

Signature of Patient or Parent/Guardian: ______________________________ Date: ______________