ROSEVILLE SMILES
Family and Cosmetic Dentistry

NEW PATIENT REGISTRATION

PATIENT INFORMATION

First Name: _____ Last Name: _____ Gender: _____

Date of Birth: _____ Mobile Phone #: _____ Email: _____

Address: _____

Emergency Contact Name: _____ Emergency Contact Phone #: _____

RESPONSIBLE PARTY

Relationship: _____ First Name: _____ Last Name: _____

Date of Birth: _____ Social Security Number: _____ Phone Number: _____

Email: _____

Employer Name: _____ Work Phone Number: _____

Address: _____

PREFERRED PHARMACY

Pharmacy Name: _____ Pharmacy Phone: _____

Address: _____

POLICY HOLDER

Insured First Name: _____ Insured Last Name: _____ Gender: _____

Relation to Patient: _____ Insured Social Security: _____ Date of Birth: _____

PRIMARY INSURANCE

Insurance Name: _____ Ins Phone Number: _____

Policy ID: _____ Group #: _____ Group Name: _____

Address: _____

☐ I certify I have read and I understand the questions. I acknowledge my questions have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her team, responsible for any errors or omissions that I have made in the completion of this form.

☐ I permit the office to communicate with me via text message.

☐ If I have dental insurance, my signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

☐ I hereby acknowledge a copy of the Notice of Privacy Practices has been made available to me (see form on website). I have been given the opportunity to ask any questions I may have regarding this Notice.

MEDICAL HISTORY

Patient Name:_____ Birth Date:_____

Physician's Name _____ Phone Number_____

Can we contact your physician if we have a question about your health as it relates to your treatment? ☐ ☐

Are you in good health? ☐ Yes ☐ No Height_____ Weight_____

Are you currently taking or planning to take antibiotics before dental treatment? ☐ Yes ☐ No

Have you been hospitalized in the past five years? ☐ Yes ☐ No

Have you ever had general anesthesia? ☐ Yes ☐ No Are you under care of a physician? ☐ Yes ☐ No

Have you or your family had reactions to general anesthesia? ☐ Yes ☐ No

Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, Prolia, Xgeva, or Evista in the past 12 years?

☐ Yes ☐ No

WOMEN ONLY

1-4 below for women only: (Note: antibiotics, such as penicillin, may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.)

1) Is there a possibility of pregnancy? ☐ Yes ☐ No 2) Expected delivery date _____

3) Are you nursing? ☐ Yes ☐ No 4) Are you taking birth control pills? ☐ Yes ☐ No

ALLERGIES/REACTIONS

Y	N		Y	N		Y	N		Y	N	
☐	☐	Penicillin	☐	☐	Sulfa drugs	☐	☐	Local anesthetic	☐	☐	Amoxicillin
☐	☐	Aspirin	☐	☐	Codeine or other narcotics	☐	☐	Latex	☐	☐	Do you have any known allergies

Please list any allergies not listed above

MEDICAL CONDITIONS

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N		Y	N	
☐	☐	AIDS / HIV	☐	☐	Dementia	☐	☐	High blood pressure	☐	☐	Prosthetic implant
☐	☐	Alzheimer's	☐	☐	Diabetes	☐	☐	High cholesterol	☐	☐	History of Radiation
☐	☐	Anemia	☐	☐	Do you smoke or vape	☐	☐	History of alcohol / drug abuse	☐	☐	Respiratory problems
☐	☐	Arthritis / Joint disease	Number of smoke/day			☐	☐	History of marijuana / drug use	☐	☐	Rheumatic fever
☐	☐	Asthma	☐	☐	Do you use chewing tobacco	☐	☐	Infectious mononucleosis	☐	☐	Sexually transmitted diseases
☐	☐	Bleeding tendency	☐	☐	Emphysema	☐	☐	Irregular heart beat	☐	☐	Sleep apnea / CPAP
☐	☐	Blood transfusion	☐	☐	Eye disease / Glaucoma	☐	☐	Joint replacement	☐	☐	Special diet
☐	☐	Bronchitis	☐	☐	Fainting spells	☐	☐	Kidney trouble	☐	☐	Stomach ulcers / acid reflux
☐	☐	Bruise easily	☐	☐	Hay fever / Sinus problems	☐	☐	Liver disease	☐	☐	Stroke
☐	☐	Cancer	☐	☐	Heart attack(s)	☐	☐	Low blood pressure	☐	☐	Thyroid trouble
☐	☐	Chest pain / Angina	☐	☐	Heart murmur	☐	☐	Low blood sugar	☐	☐	Trouble climbing 1-2 flights of stairs
☐	☐	Chronic cough	☐	☐	Heart pacemaker	☐	☐	Mental health problems	☐	☐	Tumor or growth
☐	☐	Chronic fatigue / Night sweat	☐	☐	Heart surgery	☐	☐	Osteopenia	☐	☐	Headache
☐	☐	Convulsions / Epilepsy	☐	☐	Osteoporosis	☐	☐	Heart valve issues	☐	☐	Pneumonia
☐	☐	Delay in healing	☐	☐	Hepatitis	☐	☐	Problems with immune system	☐	☐	Have you had infective endocarditis ?

Any other medical conditions not listed above

_____

MEDICATIONS

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

Medication Name	Dosage	Frequency	Medication Name	Dosage	Frequency

PATIENT SIGNATURE

X **X**

Signature of patient (Parent or Guardian if Minor) **Date**

DOCTOR'S NOTES

X **X**

Signature of dentist **Date**

DENTAL HISTORY

Rate your mouth condition: _____ How frequently you see dentist?: _____ month(s)

Who may we thank for referring you?: _____ Most recent X-Rays: _____

Previous Dentist: _____ How long have you been patient?: _____

Date of last regular dental cleaning: _____ Most recent dental exam: _____

Describe your immediate concern:

_____

PERSONAL HISTORY

How fearful are you of dental treatment (10 being the most)?: _____

Have you had an unfavorable dental experience? ☐ Yes ☐ No

GUM AND TEETH

Do your have missing teeth? If so, are you interested in Dental Implant? ☐ Yes ☐ No

Do your teeth feel like they fit together properly when you bite down? ☐ Yes ☐ No

Have you ever had deep cleaning of your teeth? ☐ Yes ☐ No Do you clench or grind your teeth? ☐ Yes ☐ No

History of getting therapeutic botox for sore jaw muscle or headache? ☐ Yes ☐ No

Do you feel like teeth have worndown overtime? If yes, remember to ask us about smile makeover. ☐ Yes ☐ No

GETTING TO KNOW YOU

What do you expect from your visit with us today?

_____

If you could "enhance" anything about your smile what would it be?

_____

Has "fear" or "cost" ever prevented you from getting the dental treatment you need or want? ☐ Yes ☐ No

What "quality" of dentistry do you want us to focus on at this time? _____

Should you be in need of treatment at what point do you plan to "get started"?

_____

Please feel free to let us know more about how we can help make this your best dental experience.

_____