New Patient Registration Form

ID (for office use only) ____________________

Patient Information

Title: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss First Name:____________________ Last Name:____________________

Address:________________________________ City:____________________ State:____ Zip:______________

Home Phone:________________________________ Work Phone:________________________________

Cell Phone:________________________________ Pager:________________________________

E-mail:________________________________ ☐ You may contact me via e-mail

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Date of Birth:________________________________ Social Security #:________________________________

Employer:________________________________ Employer Address:________________________________

Employment Status: ☐ Full time ☐ Part time ☐ Retired Student Status: ☐ Full time ☐ Part time

Patient Preferences

Do you prefer ☐ Morning appointments? ☐ Afternoon appointments?

Who is your preferred Dentist?________________________ Hygienist?________________________

Referral Information

How did you hear about us? ☐ Yellow Pages ☐ TV ad ☐ Radio ad ☐ Dental Implant Seminar ☐ Newspaper ad

☐ Referred by a dentist________________________ ☐ Referred by a friend/relative________________________

Which dentist were you referred to?________________________________

Patient Responsibility

Who is responsible for your accounts? ☐ Self ☐ Spouse ☐ Parent ☐ Other________________________

If not yourself:

Responsible party's name:________________________________ Date of birth:________________________________

Employer:________________________________ Work phone: (   ) ________________________

Social Security #________________________________

Billing Address: ________________________________ City:____________________ State____ Zip______________

Insurance

Do you have dental insurance? ☐ No ☐ Yes ☐ Insurance Co.________________________________

Subscriber:____________________ Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other______________

Subscriber's employer:________________________ Social Security or Policy ID #________________________

Do you have secondary dental insurance? ☐ No ☐ Yes ☐ Insurance Co.________________________________

Subscriber:____________________ Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other______________

Subscriber's employer:________________________ Social Security or Policy ID #________________________

TURN OVER AND FILL OUT REVERSE SIDE

Medical History for________________________________ Patient Name________________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medication you may be taking could affect the dental care you will receive. Thank you for answering these questions.

Are you under a physician's care now?.. ☐ No ☐ Yes For what?________________________

Have you ever been hospitalized or had a major operation?........... ☐ No ☐ Yes For what?________________________

Have you ever had a serious head or neck injury? .... ☐ No ☐ Yes Describe________________________

Are you taking any medications, pills or drugs? .... ☐ No ☐ Yes List________________________

Do you/have you ever taken Phen-Fen or Redux?.......................... ☐ No ☐ Yes

Do you use tobacco?.. ☐ No ☐ Yes

Do you use controlled substances? .... ☐ No ☐ Yes

Are you on a special diet? .... ☐ No ☐ Yes Describe________________________

Women: Are you ☐ Pregnant/trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Latex ☐ Local anesthetics ☐ Other________________________

Do you/have you ever had the following conditions?

☐ AIDS/HIV Positive
☐ Alzheimer's disease
☐ Anaphylaxis
☐ Anemia
☐ Angina
☐ Arthritis/gout
☐ Artificial heart valve
☐ Artificial joint
☐ 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
☐ Easily winded
☐ 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 pacemaker
☐ Heart trouble/ disease
☐ 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
☐ Pain in jaw joints
☐ 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
☐ Swelling of limbs
☐ Thyroid disease
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors or growths
☐ Ulcers
☐ Venereal disease
☐ Yellow jaundice

Have you ever had a serious illness not listed above? ☐ No ☐ Yes________________________

Payment Method (check one)________________________

☐ I prefer to pay at each appointment by: ☐ Cash or check ☐ MasterCard ☐ Visa ☐ Discover. Dental insurance benefits will be reimbursed directly to me.
☐ I want to apply for a CareCredit Card to make monthly payments over an extended period of time.
☐ I have BCBS of Rochester or MetLife insurance coverage. Elmwood Dental Group will be reimbursed directly for my treatment. I will be responsible for any balance not covered by my insurer.

I hereby authorize Elmwood Dental Group, PC to inquire about my credit history through the Credit Bureau of Rochester. Any remaining balance on my account is my responsibility. I agree to pay my balance plus finance charges at the highest level rate and reasonable collection costs and/or attorneys fees incurred by Elmwood Dental Group, PC if my balance is not paid.

I hereby authorize Elmwood Dental Group, P.C. to release any medical or other information necessary to process my insurance claim forms.

I hereby authorize Elmwood Dental Group, P.C. to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The above information is accurate to the best of my knowledge.

Signed________________________________ Date________________________
(parent or guardian, if patient is a minor)

OFFICE USE ONLY Referred by:________________________ Referred to:________________________