

NEW PATIENT REGISTRATION

Patient Name: _____ Date of Birth: _____

Home Address: _____
Street city state zip

Home telephone _____ Business telephone _____ Cell telephone _____

Email address _____

Social Security Number _____ Marital status _____

Name, address and relationship of responsible party (if different) _____

Referral source _____ Reason for visit _____

PRIMARY DENTAL INSURANCE

Subscriber Name _____ Subscriber ID _____

Insurance carrier name and address and phone number _____

Employer name _____ Employer group number _____

Relationship to subscriber _____ Subscriber DOB _____

SECONDARY DENTAL INSURANCE

Subscriber Name _____ Subscriber ID _____

Insurance carrier name and address and phone number _____

Employer name _____ Employer group number _____

Relationship to subscriber _____ Subscriber DOB _____

PRIMARY MEDICAL INSURANCE

Subscriber Name _____ Subscriber ID _____

Insurance carrier name and address and phone number _____

Employer name _____ Employer group number _____

Relationship to subscriber _____ Subscriber DOB _____

NEW PATIENT HEALTH HISTORY

Physician name _____ Telephone Number _____

Physician address _____
Street city state zip

Are you allergic or have you ever reacted adversely to any medication or substance? If yes, explain: _____

Are you currently taking any medications? If yes, list name and dosages: _____

Please circle yes or no to any of the following that apply:

Heart failure	yes	no	Stroke	yes	no	Hepatitis A	yes	no
Heart disease or attack	yes	no	Artificial limbs	yes	no	Hepatitis B	yes	no
Angina Pectoris	yes	no	Kidney problems	yes	no	STD	yes	no
Congenital Heart Disease	yes	no	Ulcers	yes	no	AIDS	yes	no
Heart murmur	yes	no	Diabetes	yes	no	HIV positive	yes	no
High blood pressure	yes	no	Thyroid problems	yes	no	Cold sores/blisters	yes	no
Arteriosclerosis	yes	no	Glaucoma	yes	no	Blood transfusion	yes	no
Mitral valve prolapse	yes	no	Cosmetic surgery	yes	no	Hemophilia	yes	no
Artificial heart valve	yes	no	Emphysema	yes	no	Anemia	yes	no
Heart pacemaker	yes	no	Chronic cough	yes	no	Sickle Cell Disease	yes	no
Heart Surgery	yes	no	Tuberculosis	yes	no	Epilepsy/seizures	yes	no
Rheumatic fever	yes	no	Asthma	yes	no	Fainting/dizzy spells	yes	no
Arthritis	yes	no	Hay fever	yes	no	Nervousness	yes	no
Jaw pain	yes	no	Sinus problems	yes	no	Psychiatric treatment	yes	no
Reheumatism	yes	no	Radiation therapy	yes	no	Undiagnosed condition	yes	no
Cortisone treatment	yes	no	Chemotherapy	yes	no			
Drug addiction	yes	no	Liver disease	yes	no			

When walking up stairs or taking a walk, do you ever have to stop due to chest pain or shortness of breath? yes no

Do your ankles ever swell during the day? yes no

Do you use more than two pillows to sleep? yes no

Do you, or have you ever been told you snore? yes no

Do you ever wake from sleep and feel a shortness of breath? yes no

Have you lost or gained more than ten pounds in the last year? yes no

Are you on a special diet? yes no

Has your physician ever mentioned your having a tumor or cancer? yes no

For women only: Are you pregnant? If yes, what month are you due? _____ Are you nursing? _____
 Are you taking birth control pills? If yes, name and dosage _____

NOTE: Any changes in your health status should be reported to the office at the earliest possible time

PATIENT AUTHORIZATION

The undersigned hereby authorizes Alpine Dental to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize alpine Dental to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with (patient's name) _____ and further authorize and consent that Alpine Dental choose and employ such assistance as deemed necessary. I also understand that the use of anesthetic agents embodies a certain risk. I understand that I am responsible for payment in full at the time services are provided for me and my dependents. I further understand that an 18% annual finance charge will be added to my balance after 90 days. In the event of default, I promise to pay the legal interest of the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this debt.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

Signature of responsible party (if different) _____ Witness _____

DENTAL HISTORY

Date of your last dental visit _____

Reason for your last visit (or series of visits) _____

Do you have any of your dental records and/or radiographs? _____

How often do you brush your teeth? _____

Do you use dental floss? _____

During any past dental treatment, have you ever fainted? If yes, please explain _____

ever had any abnormal bleeding? _____

had any allergic reactions to materials or medications? If yes, please explain _____

had any other complications following dental treatment? If yes, please explain _____

Do your gums bleed or hurt when brushing or eating?	yes	no
Does food catch between any teeth?	yes	no
Have your teeth shifted – are there now spaces where there were none?	yes	no
Are any of your teeth loose?	yes	no
Do you feel your breath is sometimes offensive?	yes	no
Are any of your teeth sensitive to heat, cold or pressure?	yes	no
Do you have any pain or clicking around the jaw joint or you ear?	yes	no
Do you grind your teeth or clench your jaw?	yes	no
Do you have frequent head, neck or shoulder aches?	yes	no
Are there any sores or growths in your mouth?	yes	no

Have you ever had any deep scaling or gum surgery? If yes please, what, where and when? _____

If you have lost teeth in the past, how and when were they replaced? (bridges, partial dentures, etc)and are you satisfied with the result?

Do you have any other dental complaints? If so, please explain _____

PERMISSION TO RELEASE HEALTH INFORMATION

I grant the dentists and/or staff of Alpine Dental to release health information obtained from me, and information about my dental treatment to third party payers (medical/dental insurance) and/or other health practitioners.

Patient Name _____

Date _____

Person completing form _____

Relationship _____

Dentist's signature _____