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 agree to receive SMS updates at the phone number provided above and understand that message frequency may vary. Msg & data rates may apply. Reply STOP to opt out.

☐ 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 Are you under care of a physician? ☐ Yes ☐ No

Have you ever had general anesthesia? ☐ 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

## 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

_____

X _____ X _____

**Signature of patient** **Date** **Signature of dentist** **Date**

## MEDICATIONS

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

| Medication Name | Dosage | Frequency | Medication Name | Dosage | Frequency |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## 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 you 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.

_____

## DOCTOR'S NOTES