Signature Dental
New Patient Registration Form

Our goal is to help you reach and maintain maximum oral health. Thank you for visiting Signature Dental. We want your visit to be pleasant and comfortable. Please fill out this form completely. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us-we will be happy to help.

Patient Information

First Name _____ M.I. ____ Last Name _____ Preferred Name _____

Sex: ❑ Male ❑ Female Birth Date: ___/___/_____ Age: _____ Social Security # _____

Home Address _____ City _____ State _____ Zip _____

Phone: Home (_____) _____ Work (_____) _____ Cell (_____) _____ E-Mail _____

Preferred Method of Contact: ❑ Home ❑ Work ❑ Cell ❑ Email Can we send you appointment reminders by E-Mail: ❑Yes ❑No

Marital Status: ❑ Minor ❑ Single ❑ Married ❑ Other

Employer/School _____ Occupation _____

Employer/School Address _____ City _____ State _____ Zip _____

Whom may we thank for referring you? ❑ Insurance ❑ Internet ❑ Direct Mail ❑ Newspaper ❑ Signage ❑ Yellow Pages ❑ Family

❑ Friend (name) _____ ❑ Dr. _____ ❑ Other _____

Other family members seen by us _____

Contact Person in case of Emergency _____ Phone (_____) _____ Relationship to Patient _____

Responsible Party

❑ Same as above, then skip to next section.

Name of Person Responsible for this Account: _____

Relationship to Patient: ❑ Spouse ❑ Mother ❑ Father ❑ Other_____ Home Phone (_____) _____

Address (if different than above) _____ City _____ State _____ Zip _____

Social Security # _____ Birth Date ___/___/_____

Employer _____ Occupation_____

Insurance Information

Primary Insurance Company

Insurance Type: ❑ Dental ❑ Medical

Insurance Co. Name _____ Insurance Co. Address _____

Insurance Co. Phone (_____) _____ Group # _____ Policy # _____

Insured's Name _____ Relation _____ Insured's Birth Date ____/____/_____

Insured's S.S. # _____ Insured's Employer _____

Employer Address _____ Work Phone (_____) _____

Secondary Insurance Company (if applicable)

Insurance Type: ❑ Dental ❑ Medical

Insurance Co. Name _____ Insurance Co. Address _____

Insurance Co. Phone (_____)_____ Group # _____ Policy # _____

Insured's Name _____ Relation _____ Insured's Birth Date ____/____/_____

Insured's S.S. # _____ Insured's Employer _____

Employer Address _____ Work Phone (_____) _____

Medical History

Name of Physician _____ Phone (_____) _____ Date of Last Physical _____

Do you have or have you ever had any of the following? (Please answer all the questions)

Y	N		Y	N		Y	N		Y	N	
❑	❑	Abnormal Bleeding	❑	❑	Cancer	❑	❑	Heart Murmur*	❑	❑	Respiratory Problems
❑	❑	ADHD (Attention Deficit Hyperactivity Disorder)	❑	❑	Chemotherapy	❑	❑	Heart Surgery	❑	❑	Rheumatic Fever*
❑	❑	Alcohol /Drug Abuse	❑	❑	Colitis	❑	❑	Hemophilia	❑	❑	Seizures
❑	❑	Allergies	❑	❑	Congenital Heart Defect	❑	❑	Hepatitis	❑	❑	Sexually Transmitted Disease
❑	❑	Anemia	❑	❑	Diabetes	❑	❑	Herpes / Fever Blisters	❑	❑	Shingles
❑	❑	Angina Pectoris/Chest Pain	❑	❑	Difficulty Breathing	❑	❑	High Blood Pressure	❑	❑	Sickle Cell Disease
❑	❑	Arthritis/ Gout	❑	❑	Emphysema	❑	❑	Kidney Problems	❑	❑	Sinus Problems
❑	❑	Artificial Heart Valve*	❑	❑	Epilepsy	❑	❑	Leukemia	❑	❑	Smoke /Tobacco Use
❑	❑	Artificial joints*	❑	❑	Fainting or Dizzy Spells	❑	❑	Liver Disease	❑	❑	Stroke
❑	❑	Asthma	❑	❑	Frequent Headaches	❑	❑	Low Blood Pressure	❑	❑	Thyroid Problems
❑	❑	Blood Disease	❑	❑	Glaucoma	❑	❑	Mitral Valve Prolapse*	❑	❑	Tuberculosis
❑	❑	Blood Thinner	❑	❑	Hay Fever	❑	❑	Pacemaker*	❑	❑	Ulcers
❑	❑	Blood Transfusion	❑	❑	HIV/ AIDS	❑	❑	Psychiatric Problems	❑	❑	Venereal Disease
			❑	❑	Heart Attack	❑	❑	Radiation Treatment			

*This condition may require antibiotic premedication for certain dental procedures.

Y	N	
❑	❑	Do you have any health problems that were not listed above or need further clarifications? If yes, explain: _____
❑	❑	Are you now under the care of a physician? If yes, explain: _____
❑	❑	Have you been admitted to a hospital or needed emergency care during the past two years? If yes, explain: _____
❑	❑	Are you taking any medications or herbals? If yes, list: _____
❑	❑	Are you allergic to any medications or substances? If yes, please check box below: ❑ Aspirin ❑ Penicillin/Amoxicillin ❑ Codeine ❑ Iodine ❑ Metal ❑ Latex ❑ Sulfa drugs ❑ Dental anesthetics ❑ Barbiturates ❑ Sedatives ❑ Erythromycin ❑ Tetracycline ❑ Other _____
❑	❑	Have you used tobacco? If yes, explain: _____

WOMEN (Please check): ❑ Pregnant # of weeks_____ ❑ Trying to get pregnant ❑ Nursing ❑ Taking oral contraceptives

Dental History

Name of Previous Dentist _____ Date of Last Dental Exam_____

Reason for today's visit: ❑ Exam ❑ Tooth cleaning ❑ Consultation ❑ Emergency ❑ Other

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Are you currently in pain? ❑ Yes ❑ No

Are you concerned about or experiencing any of the following dental problems? (please tick as many as it applies)

❑ Bad Breath	❑ Grinding Teeth	❑ Prolonged bleeding following extraction	❑ Sores or Growth in your Mouth
❑ Bleeding Gums	❑ Loose Teeth or Broken Fillings	❑ Sensitivity to Hot or Cold	
❑ Clicking or Popping Jaw	❑ Periodontal Treatment	❑ Sensitivity to Sweet or Sour	
❑ Food Collection between Teeth	❑ Roughness or discoloration of existing fillings	❑ Sensitivity when Biting	

Are you concerned with: (please tick as many as it applies)

❑ Existing crowns, bridges or dentures	❑ Ability to eat	❑ Gaps between your teeth
❑ Tooth clean techniques (e.g. Brushing / Flossing)	❑ Your smile	❑ Discoloration of your teeth
❑ Crooked teeth ❑Missing teeth	❑ Silver fillings	❑ Previous dental treatment

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examinations rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependents.

X_____ _____

Signature of patient (or parent/guardian if minor) Date

_____

Printed Name