Patient Registration

Personal Information

Patient Full Name _____ Preferred Name_____ Birth Date_____

Home Address_____ City_____ State_____ Zip_____

SS#_____ Home # ( )_____ Cell Phone # ( )_____ Work # ( )_____

Email Address_____ Spouse's Name_____ Referred By_____

Emergency Contact (Guardian if a minor)_____ Relationship_____ Phone # ( ) _____

Employer _____ Do you have dental insurance : Yes □ No □

Preferred Pharmacy and Location _____

Reason for visit _____

Circle any service you would like to discuss further

Implants Cosmetic Services Sedation Teeth Straightening/Ortho Snoring/Sleep Apnea

Medical Information

Yes or No - Are you currently under the care of a physician?
Yes or No - Are you allergic to any medications? List _____
Yes or No - Are you pregnant? How many weeks? _____
Yes or No - Do you have any artificial joints? When and what joint? _____
Yes or No - Do you have any history of infective endocarditis or heart transplant?
Yes or No - Do you have history of prosthetic heart valve repair or congenital heart defect?
Yes or No - Have you ever taken any bisphosphonate therapy including Fosamax, Boniva, Reclast,Actonel, etc?
Yes or No - Do you take blood pressure medication?
Yes or No - Do you have a history of heart attack or stroke?
Yes or No - Do you take or have recently taken blood thinners? List_____
Yes or No - Do you have any bleeding disorder?
Yes or No - Do you have diabetes?
Yes or No - Do you have kidney disease?
Yes or No - Do you have liver disease?
Yes or No - Do you smoke, chew or dip tobacco?
Yes or No - Do you have a history of drug addiction or use?
Yes or No - Do you have HIV or Hepatitis B or C?
Yes or No - Do you have a history of cancer?
Yes or No - Do you take medication for anxiety?
Yes or No - Do you take medication for or have ever been treated for any psychiatric condition?
Yes or No - Do you have a history of periodontal disease?
Yes or No - Do you have a history of grinding your teeth (bruxism)?
Yes or No - Do you have a history of TMJ pain?

Please list any major illness, hospitalization, or condition not listed above_____

Please list current medications_____

Please list treating medical doctors that you are under the care of_____

I verify that the preceding information is true. I authorize the release of information to my insurance company. I authorize release of any information relating to my claim. I authorize payment directly to Hopewell Family Dentistry. I understand all fees not paid by my insurance company is my responsibility. I will allow the Doctors and Staff of Hopewell Family Dentistry to discuss my conditions with my physicians(s) and specialist and to request information from them. I acknowledge that I have been given or offered a copy of the office's "Notice of Privacy Practice" as well as "Hopewell Family Dentistry's Financial and Appointment Policies".

Signature_____ Date _____