GIBSON DENTAL

New Patient Registration

Name: (*First)*_____(*Last*)_____ (*Middle Initial)* _____

(*Preferred Name*) _____

Address: _____

_____

(*City*)_____(*State*)_____(*Zip*)_____

Phone: (*Home*)_____(*Cell*)_____(*Work*)_____

Email: _____

Date of Birth: _____**SSN:** _____

Sex: Male Female **Marital Status:** Single Married Child Widowed Divorced

Employer: _____

Emergency Contact: (Name)_____ (Phone Number**)** _____

Whom may we thank for referring you to our office? How did you hear about our office? _____

PRIMARY DENTAL INSURANCE INFORMATION

Name of Subscriber:_____ **Relationship to Subscriber:** Self Spouse Child

Subscriber DOB: _____ **Subscriber Employer:**_____

Insurance Company:_____ **Group Number:** _____

Contract #/Subscriber ID:_____

SECONDARY DENTAL INSURANCE INFORMATION

Name of Subscriber:_____ **Relationship to Subscriber:** Self Spouse Child

Subscriber DOB: _____ **Subscriber Employer:**_____

Insurance Company:_____ **Group Number:** _____

Contract #/Subscriber ID:_____

*Our system automatically sends appointment confirmations via email and text message. It helps us greatly to be able to do this. We appreciate your patience if you receive multiple reminders. We would appreciate any feedback if you have issues with this automated system.

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MEDICAL/DENTAL INFORMATION

Patient Name:(first) _____(last)_____ Preferred Name: _____DOB: _____

Primary Physician's Name: _____ Phone: _____

Previous surgeries/operations: _____

Please list all prescription and over the counter medications you take:

_____

_____

_____

Do you use tobacco (cigarettes, smokeless tobacco, etc.)? . Yes No If yes, how much and for how long? _____

Do you drink alcoholic beverages? ..... Yes No

Do you take or have you EVER taken any medications containing bisphosphonates (like Fosamax, Boniva, Actonel, Atelvia, Reclast, Prolia)? ..... Yes No

Have you EVER taken Phen-Fen or Redux? ..... Yes No

Women, are you: Pregnant/trying to get pregnant? ..... Yes No

Nursing? ..... Yes No

Taking birth control? ..... Yes No

Do you have any allergies (other than seasonal allergies)? .. Yes No

Penicillin Sulfa Drugs Aspirin Local Anesthetics Other medication_____

Codeine Any Metals Latex Any foods or other substances_____

Do you have, or have you had, any of the following?

Artificial joint.....	Yes	No	AIDS or HIV.....	Yes	No	Diabetes type I or II	Yes	No
Artificial heart valve	Yes	No	Hepatitis B or C.....	Yes	No	Hypoglycemia.....	Yes	No
Congenital heart disease	Yes	No	Sexually transmitted disease	Yes	No	Acid reflux/GERD.....	Yes	No
Cardiovascular disease	Yes	No	Cold sores/fever blisters.....	Yes	No	Eating disorder	Yes	No
Congestive heart failure	Yes	No	Autoimmune disease.....	Yes	No	Stomach ulcers.....	Yes	No
Heart attack.....	Yes	No	Rheumatoid arthritis	Yes	No	Thyroid problems	Yes	No
Stroke.....	Yes	No	Tuberculosis	Yes	No	Steroid/cortisone medication ..	Yes	No
Angina	Yes	No	Asthma	Yes	No	Glaucoma	Yes	No
Infective endocarditis.....	Yes	No	Emphysema/COPD/bronchitis..	Yes	No	Kidney or liver problems	Yes	No
High blood pressure	Yes	No	Sinus trouble	Yes	No	Obstructive Sleep Apnea	Yes	No
Pacemaker.....	Yes	No	Anaphylaxis	Yes	No	Seizures/Epilepsy	Yes	No
Rheumatic heart disease	Yes	No	Cancer	Yes	No	Mental health disorder	Yes	No
Abnormal bleeding/clotting	Yes	No	Chemotherapy/Radiation...	Yes	No	Illicit drug use.....	Yes	No

Has a physician ever recommended that you routinely take antibiotic premedication before dental appointments? ... Yes No

Are there any other health conditions not listed that you have experienced? Is there anything else you think we should know?

_____

Please check any dental concerns you have so that we may focus our exam to better serve you:

Tooth pain	Straightening teeth	Worn teeth
Sensitive teeth	Bleaching/whitening	Grinding/clenching teeth at night
Frequent cavities	Replacing missing teeth	Jaw pain/clicking/popping
Dry mouth	Bleeding gums	Frequent headaches
Bad breath	Periodontal/gum disease	Other: _____

Is there anything that bothers you about the appearance of your smile? _____

I have read and understand the above questions and have answered them to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status. I will not hold my dentist or his staff responsible for any actions they do or do not take because of errors and/or omissions that I have made on this form.

Signature of Patient/Guardian: _____Date: _____

Signature of Dentist: _____Date: _____