New Patient Registration

MtnView FAMILY DENTISTRY

Date

Patient Information

Last Name | First Name | Gender ○ Male ○ Female

Street Address | Street Address line 2

City | State | Zip code

Social Security # | Date of Birth

License/ID # | Marital Status

Home # | Work # | Cell Phone #

E-mail Address | How did you hear about us?

How would you like us to contact you? (Check all that apply)

☐ E-mail ☐ Home phone ☐ Cell phone ☐ Text

☐ Other

Employment Information

Employer/School | Occupation

Employer Address | Street Address line 2

City | State | Zip code

Insurance Information

Subscriber Last Name | Subscriber First Name

Date of Birth | Social Security #

Dental Insurance Carrier | Group #

City | State | Zip code

Emergency Contact

Emergency Contact Name	Emergency Contact Phone #	Relationship

The above information is true and correct to the best of my knowledge. I authorize and give consent to perform dental services agreed between doctor, patient, and/or guardian to be necessary or advisable, including the use of local anesthesia and other medications as indicated. I understand that payment is expected as services are rendered unless prior financial arrangements have been made.

Signature	Date

Cancellation Policy

If you are unable to keep your appointment, please give us 48 hours notice otherwise we reserve the right to charge you a $75 cancellation fee.

I have read and understand the cancellation policy:

Signature	Date

Medical History

Are you currently in good health? ◯ Yes ◯ No

Has there been changes to your health within the last year? ◯ Yes ◯ No

Have you been hospitalized or had a serious illness? ◯ Yes ◯ No

If so, please explain below:

Date of last medical exam:

Date of last dental exam:

Are you currently being treated by a physician?

◯ Yes ◯ No

If yes, what are you being treated for?

Physician name:

Physician phone #:

Have you experienced or are you currently experiencing any of the following? (check all that apply)

- ☐ Allergies/hives/hay fever
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial heart valve
- ☐ Artificial joint
- ☐ Asthma
- ☐ Bleeding problems
- ☐ Blood transfusion
- ☐ Bruise easily
- ☐ Chemotherapy
- ☐ Chest pain (Angina)
- ☐ Cold sores
- ☐ Congenital heart lesions
- ☐ Epilepsy/seizures
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug addiction
- ☐ Dry mouth
- ☐ Emphysema
- ☐ Fainting spells
- ☐ Frequent vomiting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart disease or attack
- ☐ Heart failure
- ☐ Heart murmur
- ☐ Heart pacemaker
- ☐ Heart surgery
- ☐ Hemophilia
- ☐ Hepatitis A (infectious)
- ☐ Hepatitis B (serum)
- ☐ Herpes
- ☐ High blood pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Joint pain/TMJ
- ☐ Kidney trouble
- ☐ Liver disease
- ☐ Persistent cough
- ☐ Psychiatric treatment
- ☐ Rheumatic fever
- ☐ Rheumatism
- ☐ Ringing in ears
- ☐ Scarlet fever
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐ Stroke
- ☐ Swollen ankles
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal disease
- ☐ X-ray/cobalt treatment
- ☐ Other

Have you had an unfavorable (allergic) reaction to any of the following? (check all that apply)

☐ Aspirin ☐ Anesthetics ☐ Codeine ☐ Latex gloves ☐ Penicillin

☐ Other drugs

Please list all drugs you are currently taking:

Are you currently experiencing pain or discomfort? ◯ Yes ◯ No

Do you feel nervous about having a dental treatment? ◯ Yes ◯ No

Have you ever had a bad experience in a dental office? ◯ Yes ◯ No

Have you ever experienced excessive bleeding requiring special treatment? ◯ Yes ◯ No

Have you had any serious trouble associated with a previous dental treatment? ◯ Yes ◯ No

If yes, please explain:

Are you on a special diet? ◯ Yes ◯ No

Do you have any disease, condition, or problem not listed? ◯ Yes ◯ No

If yes, please explain:

Women:

Are you pregnant? ◯ Yes ◯ No

Are you currently on birth control? ◯ Yes ◯ No

Do you anticipate becoming pregnant? ◯ Yes ◯ No

To the best of my knowledge, all of the preceding answers are true and correct. I understand that my medical history is confidential and necessary for Mountain View Family Dentistry's files and for my health. If I experience a change in my health or medicine, I will inform Dr. Pedraza at the next appointment without fail.

Signature

Date

Reviewed by

Date