NEW PATIENT REGISTRATION FORM

KENWOOD COMPLETE DENTISTRY

ABOUT YOU

Today's Date _____

Name _____ I prefer to be called _____
First Last

Home Address _____
Address City, State Zip

Do you: ☐ Rent ☐ Own Are you: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Phone ( ) _____ ( ) _____ ( ) _____
Home Work Mobile

Email _____ What is the best way to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us? _____

Employer _____ How long there? _____ Occupation _____

Spouse's Name (if applicable) _____ Spouse's Employer _____

Who should we contact in case of emergency? _____ ( ) _____
Name Phone

Who is responsible for this account? _____

DENTAL INSURANCE INFORMATION

Insurance Company Name _____

Group # _____ Phone ( ) _____

Insurance Company's Address: _____
Address City, State Zip

Insured's Name: _____ Insured's Soc. Sec. # _____

Insured's Birthdate __ __ _____ Insured's Employer _____

Relationship to you _____ Do you have secondary insurance? ☐ Yes ☐ No

DENTAL HISTORY

Why have you come to the dentist today?_____

When was your last dental visit?_____ Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Would you like fresher breath? ☐ Yes ☐ No Are your teeth sensitive to hot, cold, or pressure? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had any serious complications with previous dental treatment? ☐ Yes ☐ No

If so, please describe_____

Is there a reason you would like us to know why you left your previous dentist?_____

_____

If you could change your smile, would you (check all that apply):

☐ Make it whiter ☐ Make it straighter ☐ Close spaces ☐ Replace old metal fillings ☐ Replace chipped teeth

☐ Replace missing teeth ☐ Replace old crowns that don't match ☐ Have a smile makeover

On a scale of 1-10, with 10 being the highest:

How important is your dental health to you?	1	2	3	4	5	6	7	8	9	10
Where would you rate your current dental health?	1	2	3	4	5	6	7	8	9	10
Where do you want your dental heath to be?	1	2	3	4	5	6	7	8	9	10

MEDICAL HISTORY

Physician's Name_____ Phone (_____)_____

Date of last visit: ___/___/_____ Your current physical health is: ☐ Good ☐ Fair ☐ Poor

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

If yes, please explain:_____

Are you allergic to any of the following? (check all that apply)

☐ Penicillin ☐ Metals/Jewelry ☐ Aspirin ☐ Erythromycin ☐ Latex ☐ Dental Anesthetics ☐ Sulfa Drugs

☐ Codeine ☐ Other_____

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

Abnormal Bleeding	Y / N	Pacemaker	Y / N	Heart Surgery	Y / N	Emphysema	Y / N
Arhritis	Y / N	Rheumatic Fever	Y / N	HIV/AIDS	Y / N	Fever Blisters	Y / N
Cancer/Malignancy	Y / N	Tuberculosis	Y / N	Low Blood Pressure	Y / N	Heart Attack	Y / N
Diabetes	Y / N	Alcohol Abuse	Y / N	Radiation Treatment	Y / N	Hepatitis	Y / N
Epilepsy	Y / N	Artificial Joints	Y / N	Seizures	Y / N	Kidney Problems	Y / N
Glaucoma	Y / N	Chemotherapy	Y / N	Ulcers	Y / N	Mitral Valve Prolapse	Y / N
Heart Murmur	Y / N	Drug Abuse	Y / N	Anemia	Y / N	Osteoporosis	Y / N
High Blood Pressure	Y / N	Fainting Spells	Y / N	Asthma	Y / N	Stroke	Y / N
Liver Disease	Y / N	Migraines	Y / N	Congenital Heart Disease	Y / N	Venereal Disease	Y / N

Please list any serious medical conditions you have experienced: _____

Are you taking any prescription or over the counter drugs? ☐ Yes ☐ No

If so, please list: _____

Do you smoke or use tobacco in another form? ☐ Yes ☐ No

Do you take a daily aspirin or any blood thinners? ☐ Yes ☐ No

WOMEN:

Are you currently pregnant? ☐ Yes ☐ No If so, how many weeks? _____

Are you taking birth control pills? ☐ Yes ☐ No

Are you taking/have you taken medication for osteoporosis? ☐ Yes ☐ No

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

Signature _____ Date ___ ___ _____