ROSEVILLE SMILES

NEW PATIENT REGISTRATION

PATIENT INFORMATION

First Name

Last Name

Date of Birth

Gender

Mobile Phone #

Email

Address

Emergency Contact Name

Emergency Contact Phone #

RESPONSIBLE PARTY

Relationship

First Name

Last Name

Email

Date of Birth

Social Security Number

Phone Number

Employer Name

Work Phone Number

Address

PREFERRED PHARMACY

Pharmacy Name

Pharmacy Phone

Address

☐ I certify I have read and I understand the questions. I acknowledge my questions have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her team, responsible for any errors or omissions that I have made in the completion of this form.

☐ I permit the office to communicate with me via text message.

☐ If I have dental insurance, my signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

☐ I hereby acknowledge a copy of the Notice of Privacy Practices has been made available to me (see form on website). I have been given the opportunity to ask any questions I may have regarding this Notice.

POLICY HOLDER

Insured First Name

Insured Last Name

Relation to Patient

Gender

Insured Social Security

Date of Birth

INSURANCE INFORMATION

Insurance Name

Policy ID

Ins Phone Number

Group #

Group Name

Address

DENTAL HISTORY

How fearful are you of dental treatment (10 being the most)?

Have you ever had braces, or had your bite adjusted? ☐ Yes ☐ No

Have you ever had gum surgery? ☐ Yes ☐ No

Have you ever had deep cleaning of your teeth? ☐ Yes ☐ No

Do you have any dental implants in your mouth? ☐ Yes ☐ No

Date of last deep cleaning

X **X**

Signature of patient (Parent or Guardian if Minor) **Date**

MEDICAL HISTORY

Patient Name: Birth Date:

Are you in good health? ☐ Yes ☐ No Height Weight 0 Are you under care of a physician? ☐ Yes ☐ No

Are you currently taking or planning to take antibiotics before dental treatment? ☐ Yes ☐ No Have you been hospitalized in the past five years? ☐ Yes ☐ No

Have you ever had general anesthesia? ☐ Yes ☐ No Have you or your family had reactions to general anesthesia? ☐ Yes ☐ No

Have you had the COVID vaccination? ☐ Yes ☐ No

Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, Prolia, Xgeva, or Evista in the past 12 years?

☐ Yes ☐ No

WOMEN ONLY

1-4 below for women only: (Note: antibiotics, such as penicillin, may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.)

1) Is there a possibility of pregnancy? ☐ Yes ☐ No

2) Expected delivery date _____

3) Are you nursing? ☐ Yes ☐ No

4) Are you taking birth control pills? ☐ Yes ☐ No

ALLERGIES/REACTIONS

Y	N		Y	N		Y	N		Y	N	
☐	☐	Penicillin	☐	☐	Sulfa drugs	☐	☐	Local anesthetic	☐	☐	Amoxicillin
☐	☐	Aspirin	☐	☐	Codeine or other narcotics	☐	☐	Latex	☐	☐	Do you have any known allergies

Please list any allergies not listed above _____

MEDICAL CONDITIONS

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N		Y	N	
☐	☐	AIDS / HIV	☐	☐	Dementia	☐	☐	High blood pressure	☐	☐	Prosthetic implant
☐	☐	Alzheimer's	☐	☐	Diabetes	☐	☐	High cholesterol	☐	☐	History of Radiation
☐	☐	Anemia	☐	☐	Do you smoke or vape	☐	☐	History of alcohol / drug abuse	☐	☐	Respiratory problems
☐	☐	Arthritis / Joint disease	Number of smoke/day			☐	☐	History of marijuana / drug use	☐	☐	Rheumatic fever
☐	☐	Asthma	☐	☐	Do you use chewing tobacco	☐	☐	Infectious mononucleosis	☐	☐	Sexually transmitted diseases
☐	☐	Bleeding tendency	☐	☐	Emphysema	☐	☐	Irregular heart beat	☐	☐	Sleep apnea / CPAP
☐	☐	Blood transfusion	☐	☐	Eye disease / Glaucoma	☐	☐	Joint replacement	☐	☐	Special diet
☐	☐	Bronchitis	☐	☐	Fainting spells	☐	☐	Kidney trouble	☐	☐	Stomach ulcers / acid reflux
☐	☐	Bruise easily	☐	☐	Hay fever / Sinus problems	☐	☐	Liver disease	☐	☐	Stroke
☐	☐	Cancer	☐	☐	Heart attack(s)	☐	☐	Low blood pressure	☐	☐	Thyroid trouble
☐	☐	Chest pain / Angina	☐	☐	Heart murmur	☐	☐	Low blood sugar	☐	☐	Trouble climbing 1-2 flights of stairs
☐	☐	Chronic cough	☐	☐	Heart pacemaker	☐	☐	Mental health problems	☐	☐	Tumor or growth
☐	☐	Chronic fatigue / Night sweat	☐	☐	Heart surgery	☐	☐	Osteopenia			
☐	☐	Convulsions / Epilepsy	☐	☐	Heart trouble	☐	☐	Osteoporosis			
☐	☐	COVID–19	☐	☐	Heart valve issues	☐	☐	Pneumonia			
☐	☐	Delay in healing	☐	☐	Hepatitis	☐	☐	Problems with immune system			

Any other medical conditions not listed above _____

MEDICATIONS

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

Medication Name	Dosage	Frequency	Medication Name	Dosage	Frequency

PATIENT SIGNATURE

X **X**

Signature of patient (Parent or Guardian if Minor) **Date**

DOCTOR'S NOTES

X **X**

Signature of dentist **Date**