[Your firm name and logo]

[Dental office name] | [Address] | [Phone]
NEW DENTAL PATIENT REGISTRATION
First visit: [MM/DD/YYYY] | Dentist: [Name]

Patient
Name: [ ] Preferred name: [ ] Date of birth: [ ] Address: [ ] Phone: [ ] Email: [ ] Preferred language: [ ] Emergency contact and phone: [ ]

Primary dental plan
Carrier: [ ] Subscriber name: [ ] Subscriber date of birth: [ ] Subscriber ID: [ ] Group number: [ ] Employer: [ ] Your relationship to the subscriber: [self / spouse / child / other]

Second dental plan (optional)
Carrier: [ ] Subscriber name and date of birth: [ ] Subscriber ID: [ ] Group number: [ ] Relationship: [ ]

Your health
Physician name and phone: [ ]. Medications, including blood thinners and bone medications: [ ]. Allergies to anesthetics, antibiotics, latex, metals or other: [ ]. Do you have or have you had: [ ] heart valve or heart condition [ ] joint replacement [ ] bleeding disorder [ ] diabetes [ ] high blood pressure [ ] hepatitis [ ] radiation to head or neck [ ] other: [ ]. Pregnant or nursing: [ ] yes [ ] no. Tobacco or vaping: [ ] yes [ ] no.

Your teeth
Reason for visit: [ ]. Last cleaning: [ ] Last X-rays: [ ] Previous dentist and phone: [ ]. Do you have: [ ] sensitivity [ ] bleeding gums [ ] jaw pain or clicking [ ] grinding [ ] dry mouth [ ] dentures or implants [ ] past orthodontics. Anything that makes dental visits hard for you: [ ]

Child patient (optional)
Parent or guardian name and phone: [ ]. Who brings the child to visits: [ ]. Thumb sucking or pacifier use: [ ] yes [ ] no.

Financial policy and consent to treatment
I have read the financial policy and I consent to dental examination and treatment.

Acknowledgment of the Notice of Privacy Practices (own signature line)
I received [Dental office name]’s Notice of Privacy Practices on [MM/DD/YYYY]. Signature: _____. Office use, if not signed: good-faith effort made and reason: _____

Signature of patient, parent or guardian: _____ Date: [MM/DD/YYYY]
Reviewed by: [Clinician initials] Date: [MM/DD/YYYY]