NEW PATIENT REGISTRATION FORM JOHN J PARIS, D.D.S. P.C.

1. PATIENT INFORMATION

Date: _____

Patient Name:_____

Social Security #: _____

Address: _____

City: _____State____ Zip_____

Sex: ___M ___F Age _____

Date of Birth:_____

Patient Employer: _____

Occupation: _____

Spouse's Name: _____

Referred by:_____

2. DENTAL INSURANCE

Person responsible for acct: _____

Subscriber #: _____ Birthdate:_____

Insurance Co.: _____

Employer of Insured: _____

Is patient covered by additional insurance: __Y __N

Subscriber's Name: _____

Subscriber # :_____ Birthdate:_____

Insurance Co. :_____

If this is a family account, do you want accounts Combined? _____ Separate? _____

I have been offered the Notice of Privacy Practices/HIPAA and have had the opportunity to review it.

Signature of Patient/Guardian

3. PHONE NUMBERS

Cell Phone ( )_____ Work ( ) _____ Ext. _____ Home Phone ( ) _____

Email: _____

How can we best contact you? Text message____ email____ voicemail (cell or home?)_____

IN CASE OF EMERGENCY CONTACT:

Name: _____ Relationship: _____

Cell Phone : ( ) _____ Work Phone: ( ) _____

4. DENTAL HISTORY

Date of last dental visit _____ Date of last dental x-rays _____

How often do you get your teeth cleaned? _____ How often do you brush? _____

How often do you floss? _____

Please indicate if you have had any of the following:

___ Clenching, grinding, TMJ pain ____ Dry Mouth

___ Bad breath ___ Loose teeth/Broken fillings ____ Cold Sores

___ Treatment for gum disease ____ Canker Sores _____Removable dentures

____ Sinus problems

Do you smoke cigarettes, cigars, a pipe or marijuana?_____

Is there a chance you may be pregnant?_____

How would you rate your level of dental anxiety (circle) 1 2 3 4 5 6 7 8 9 10

Lo hi

MEDICAL HISTORY

Thank you for answering the following questions accurately and completely. Your medical health plays an important role in the health of your mouth. As a result, it plays an important part in determining the care you will receive in this office.

Physicians Name_____ Physicians phone number_____

When was your last complete physical?_____ When were you last seen by a physician?_____

For what conditions are you currently being treated by your physician?_____

What allergies or adverse reactions to medications have you experienced in the past?_____

Please list all medications you are currently taking? _____

What medications have you taken in the last six hours?_____

Do you have a history of alcohol/drug addiction? _____

Have you ever taken a medication for osteoporosis?_____

Do you have any artificial joints or valve replacement? _____

HAVE YOU EVER BEEN DIAGNOSED WITH OR TREATED FOR ANY OF THE FOLLOWING?

HEART PROBLEMS/ HIGH BLOOD PRESSURE_____ CANCER_____ HEPATITIS_____ KIDNEY DISEASE_____

RESPIRATORY/ASTHMA/LUNG/PROBLEMS_____ MITRAL VALVE PROLAPSE/HEART MURMER_____

INTESTINAL/ULCERS/DIGESTIVE PROBLEMS_____ DIABETES_____ HIV_____

RHEUMATIC FEVER/ SCARLET FEVER/ HEMPOHILIA/ BLOOD DISEASE_____

PSYCHIATRIC CARE/ NERVOUS DISORDERS _____

The above information is accurate and complete to the best of my knowledge. I have not intentionally withheld any information regarding my medical history or other areas of this form.

I understand that I am financially responsible at the time of the appointment for services rendered.

I understand that there will be a fee charged to my account if a 24 hour notice is not given for cancelled appointments. This fee must be paid before I can be rescheduled.

I understand that this office will make every reasonable attempt to collect payment from my insurance company. If for some reason, my insurance company does not pay all or part of my balance, I am responsible for the difference and will pay within 30 days

Date_____ Signature_____