FORT DES MOINES DENTAL

NEW PATIENT REGISTRATION

First Name _____ MI _____ Last Name _____

Gender _____ Date of Birth _____ Preferred Name _____

Mailing Address _____ City _____

State _____ Zip Code _____ SSN _____

Email Address _____ Home Phone _____

Work Phone _____ Other Number _____

Employer _____ Occupation _____

Spouse _____ Spouses' DOB _____ Spouse's SSN _____

Spouse's Employer _____ Spouse's Phone _____

Referred By _____

How Did you Hear About Us? _____

Parent/Guardian Name *(if patient is a minor)* _____

Second Parent/Guardian Name _____

DENTAL INSURANCE INFORMATION

Primary Coverage

Insurance Company _____

Insured's Name _____

Insured's Employer _____

Insured's SSN _____ Insured's DOB _____

Group # _____

Secondary Coverage

Insurance Company _____

Insured's Name _____

Insured's Employer _____

Insured's SSN _____ Insured's DOB _____

Group # _____

FORT DES MOINES DENTAL

MEDICAL HISTORY

Patient Name _____ Date _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

_____ Allergy to Nickel
_____ Angina (Chest Pains)
_____ Anemia
_____ Arthritis (Osteo or Rheumatoid)
_____ Artificial Heart Valve
_____ Artificial Joint (Knee, Hope or Other)
When? _____
_____ Asthma
_____ Blood Thinner
Which One? _____
_____ Blood Disease or Blood Problems
_____ Cancer/Radiation Treatment
_____ Chemical Dependence
_____ Circulatory Problems
_____ Diabetes
Controlled _____ *Not Controlled* _____
_____ Dizziness/Fainting
_____ Epilepsy
_____ GERD
_____ Glaucoma
_____ Head Injury
_____ Heart Murmur or Mitral Valve Prolapse
_____ Hepatitis
_____ High Blood Pressure
_____ High Cholesterol
_____ HIV
_____ Kidney Disease
_____ Latex Allergy
_____ Liver Disease
_____ Malignancies
_____ Measles/Mumps
_____ Mental/Nervous Disorder
_____ Pace Maker
_____ Respiratory Problems
_____ Rheumatic Fever
_____ Scarlet Fever
_____ Sinus Problems
_____ Sleep Apnea
_____ Stomach Problems
_____ Stroke
_____ Thyroid Disease
_____ Tonsillitis
_____ Tuberculosis
_____ Ulcer
_____ Other items not listed

Do you currently need an antibiotic prior to your dental appointment? _____

Do you use Tobacco? (Chew, Smoke or Other) _____ Are you currently pregnant? _____

Medication(s) _____

_____

Allergies _____

Signature _____