New Patient Registration

(ALL INFORMATION VOLUNTEERED ON THIS FORM IS FOR DOCTOR'S USE ONLY AND WILL *NOT* BE SHARED WITH ANYONE WITHOUT YOUR CONSENT)

PLEASE FILL OUT THE FOLLOWING INFORMATION FOR THE PATIENT HAVING SURGERY TODAY

Patient First Name:	Middle:	Last:
Street Address:		
City:	State:	Zip
Social Security #:	Email Address:	
Home Phone:	Cell Phone:	

Date of Birth:	Age:	Sex:	Height:	Weight:

Please indicate ***why*** you are here today: _____

Has the patient had anything to eat or drink in the past 5 hours? ☐Yes ☐No
If yes, please explain: _____

Has the patient been treated at a hospital within the past 5 years? ☐Yes ☐No
If yes, please explain: _____

Is the patient presently under a physician's care? ☐Yes ☐No
If yes, please explain: _____

Please list any medications the patient is taking: _____

_____

Has the patient used any of the following during the *past year*? ☐Yes ☐No
If yes, please circle drugs used: Marijuana Heroin Crack Meth any other illegal drug

Is the patient allergic to any of the following? Please ☑ any that apply:

☐ Novocaine	☐ Pentothal	☐ Penicillin	☐ Sulfa Drugs	☐ Aspirin	☐ Phenergan
☐ Codeine	☐ Lortab	☐ Demerol	☐ Percocet	☐ Latex	☐ Ibuprofen

List any other drug allergies the patient has: _____

Has the patient suffered from or experienced any of the following? Please ☑ any that apply:

☐ Anemia	☐ Emphysema	☐ Hemophilia	☐ Sinus Difficulty
☐ Arthritis	☐ Excessive Bleeding	☐ Hepatitis	☐ Sleep Apnea/Snoring
☐ Asthma	☐ Glaucoma	☐ High Blood Pressure	☐ Stroke
☐ Cancer	☐ Heart Defect	☐ Jaundice	☐ Tuberculosis
☐ Chest Pain	☐ Heart Disease	☐ Nephritis	
☐ Chronic Cough	☐ Heart Murmur	☐ Rheumatic Fever	
☐ Diabetes	☐ HIV / AIDS	☐ Seizures	

Has the patient had a recent cold? ☐Yes ☐No

Is the patient pregnant (Women only)? ☐Yes ☐No

Does the patient smoke? ☐Yes ☐No
If yes, how many cigarettes per day? _____

(CONTINUED ON BACK)

Name of Patient's Dentist:	Office Located in What City:
Name of Patient's Physician:	Office Located in What City:

Do you have braces? ☐Yes ☐No

If yes, Who is your Orthodontist: _____

How did you hear about us? Please ☑ any that apply:

☐ Valpak ☐ UTA Bus Ad ☐ Billboard ☐ Friend / Family

☐ Internet ☐ Radio ☐ TV ☐ Home Town Values

☐ Dentist Referral (if checked, Dentist's name): _____

☐ Other: _____

THE FOLLOWING SHOULD BE FILLED OUT BY THE INDIVIDUAL RESPONSIBLE FOR ACCOMPANYING THE PATIENT HOME TODAY

First Name:		Last:
Street Address:		
City:	State:	Zip
Home Phone:		Cell Phone:
Age:	Relation to Patient:	

I confirm that all above information is a complete, accurate and honest representation of the patient's information and health history.

Patient or Guardian Name:	Date:
Signature: ✗	

FOR OFFICE USE ONLY:

☐ Highlights ☐ Insurance / Medicaid ☐ Consent

☐ Referral ☐ Dr. Letter ☐ Insurance info verified