



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: _____

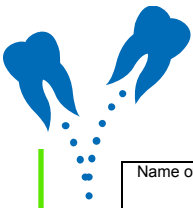
Has the patient suffered from or experienced any of the following? Please any that apply:
 Anemia Emphysema Hemophilia Sinus Difficulty
 Arthritis Excessive Bleeding Hepatitis Sleep Apnea/Snoring
 Asthma Glaucoma High Blood Pressure Stroke
 Cancer Heart Defect Jaundice Tuberculosis
 Chest Pain Heart 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:

- | | | | |
|---|-------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Valpak | <input type="checkbox"/> UTA Bus Ad | <input type="checkbox"/> Billboard | <input type="checkbox"/> Friend / Family |
| <input type="checkbox"/> Internet | <input type="checkbox"/> Radio | <input type="checkbox"/> TV | <input type="checkbox"/> Home Town Values |
| <input type="checkbox"/> Dentist Referral (if checked, Dentist's name): _____ | | | |
| <input type="checkbox"/> 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: X	

FOR OFFICE USE ONLY:

- | | | |
|-------------------------------------|---|--|
| <input type="checkbox"/> Highlights | <input type="checkbox"/> Insurance / Medicaid | <input type="checkbox"/> Consent |
| <input type="checkbox"/> Referral | <input type="checkbox"/> Dr. Letter | <input type="checkbox"/> Insurance info verified |