Koppelman Dental

# NEW PATIENT REGISTRATION

# Welcome!

DATE_____

## PATIENT INFORMATION

Patient Name _____ (first name / middle initial / last name)
Date of Birth _____
Address _____
City _____ State _____ Zip _____
Email _____
Mobile _____ Home _____ Work _____
SSN# _____
Sex ☐ M ☐ F
Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partnered

Employer/ School Name _____
Occupation _____

## DENTAL INSURANCE

Primary Subscriber of the policy _____
Relationship to patient _____
Subscriber D.O.B. _____
Subscriber SSN _____
ID number _____
Group number _____
Additional Insurance ☐ YES ☐ NO

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to Dr._____all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all the changes whether or not is paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such information to the above named Insurance Company(ies).and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed above.

_____

Signature of patient, Parent, Guardian or Personal Representative

Please Print name of Patient, Parent, Guardian or Personal Representative

## EMERGENCY CONTACT

Name _____ Relationship _____
Mobile _____ Home Phone _____

## HOW DID YOU FIND US?

☐ Google ☐ Facebook/Twitter ☐ ZocDoc ☐ Yelp
☐ Friend (tell us his/her name) _____

## DENTAL HISTORY

Reason for today's visit _____

Date of last dental visit _____ How often do you floss? _____

Date of last dental X-rays _____ How often do you brush? _____

Please mark if you have had any of the following:

| Y | N | | Y | N | | Y | N | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Bad breath | ☐ | ☐ | Food collection between the teeth | ☐ | ☐ | Orthodontic treatment |
| ☐ | ☐ | Bleeding gums | ☐ | ☐ | Foreign Objects | ☐ | ☐ | Pain around ear |
| ☐ | ☐ | Blisters on lips or mouth | ☐ | ☐ | Grinding Teeth | ☐ | ☐ | Periodontal treatment |
| ☐ | ☐ | Clicking or popping jaw | ☐ | ☐ | Gums swollen or tender | ☐ | ☐ | Sensitivity to cold |
| ☐ | ☐ | Burning sensation on tongue | ☐ | ☐ | Jaw pain or tiredness | ☐ | ☐ | Sensitivity to heat |
| ☐ | ☐ | Chew on one side of mouth | ☐ | ☐ | Lip or cheek biting | ☐ | ☐ | Sensitivity to sweets |
| ☐ | ☐ | Cigarette, pipe, or cigar smoking | ☐ | ☐ | Loose teeth or broken fillings | ☐ | ☐ | Sensitivity when biting |
| ☐ | ☐ | Dry mouth | ☐ | ☐ | Mouth breating | ☐ | ☐ | Sores or growth in your |
| ☐ | ☐ | Fingernail biting | ☐ | ☐ | Mouth pain brushing | ☐ | | mouth |

## HEALTH HISTORY

Have you ever used a Bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva

☐ yes ☐ no

Have you ever taken any of the group of drugs collectively referred as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand name of phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine) ☐ yes ☐ no

Please mark if you have had any of the following:

| Y | N | | Y | N | | Y | N | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | AIDS/HIV | ☐ | ☐ | Epilepsy | ☐ | ☐ | Radiation treatment |
| ☐ | ☐ | Anemia | ☐ | ☐ | Fainting or dizziness | ☐ | ☐ | Respiratory disease |
| ☐ | ☐ | Arthitis, rehumatism | ☐ | ☐ | Glaucoma | ☐ | ☐ | Rheumatic fever |
| ☐ | ☐ | Artificial joints | ☐ | ☐ | Headaches | ☐ | ☐ | Scarlet fever |
| ☐ | ☐ | Asthma | ☐ | ☐ | Heart mourmur | ☐ | ☐ | Shortness of breath |
| ☐ | ☐ | Back problems | ☐ | ☐ | Heart problems | ☐ | ☐ | Sinus troble |
| ☐ | ☐ | Bleeding abnormaly with surgery | ☐ | ☐ | Hepatitis type _____ | ☐ | ☐ | Skin rash |
| ☐ | ☐ | Blood disease | ☐ | ☐ | Herpes | ☐ | ☐ | Special diet |
| ☐ | ☐ | Cancer | ☐ | ☐ | High blood pressure | ☐ | ☐ | Stroke |
| ☐ | ☐ | Chemical Dependency | ☐ | ☐ | Jaundice | ☐ | ☐ | Swollen feet or ankles |
| ☐ | ☐ | Chemotherapy | ☐ | ☐ | Jaw pain | ☐ | ☐ | Swollen neck glands |
| ☐ | ☐ | Circulatory problems | ☐ | ☐ | Kidney disease | ☐ | ☐ | Thyroid problems |
| ☐ | ☐ | Congenital heart lesion | ☐ | ☐ | Liver disease | ☐ | ☐ | Tonsillites |
| ☐ | ☐ | Cortisone treatments | ☐ | ☐ | Low blood pressure | ☐ | ☐ | Tubercolosis |
| ☐ | ☐ | Cough persistent or bloody | ☐ | ☐ | Mitral valve prolapse | ☐ | ☐ | Tumor or growth neck/head |
| ☐ | ☐ | Diabetes | ☐ | ☐ | Nervous problems | ☐ | ☐ | Ulcer |
| ☐ | ☐ | Emphysema | ☐ | ☐ | Pacemaker | ☐ | ☐ | Venereal disease |
| ☐ | ☐ | Do you wear contact lenses? | ☐ | ☐ | Psychiatric Care | ☐ | ☐ | Weight loss, unexplained |

Are you pregnant? ☐ yes ☐ no Due date _____ Are you nursing? ☐ yes ☐ no

Taking birth control pills? ☐ yes ☐ no

## MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

☐ NONE

Pharmacy name _____

Phone _____

## ALLERGIES

☐ Aspirin
☐ Barbiturates
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other _____

☐ NONE