Brett Blacher DDS

NEW PATIENT REGISTRATION AND HISTORY

PATIENT INFORMATION

Date_____

Name_____

Address_____

City_____

State_____Zip_____

SS#_____

EMAIL_____

Birthdate_____

☐ Married ☐ Single ☐ Male ☐ Female

Whom may we thank for referring you?

_____

DENTAL INSURANCE

Policy Holder Name (Subscriber)

_____

SS#_____Birthdate_____

Insurance Company _____

Employer:_____

Group #_____ID#_____

Customer Service #_____

WOMEN

Are you pregnant? ☐ Yes ☐ No

Taking birth control? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

PHONE NUMBERS

Home(___)_____Work(___)_____EXT_____Cell(___)_____

IN CASE OF AN EMERGENCY , CONTACT

Name_____Relationship_____

Phone#_____Work#_____

MEDICATIONS

Please list any medications you are currently taking **INCLUDING** all over the counter medicines_____

_____

_____

_____

_____

_____

Do you require pre-medication prior to dental appointments?_____

_____

_____

Pharmacy Name_____

Pharmacy #_____

ALLERGIES or UNUSUAL REACTIONS

☐ Latex

☐ Penicillin

☐ Sulfa

☐ Local Anesthetic

☐ Codeine

☐ Metals

☐ Fluoride

☐ Other

_____

_____

_____

HEALTH HISTORY

	YES	NO
Any Heart Conditions	____	____

Angina , Chest Pain, Congestive heart failure, Coronary artery disease, heart attack, Infective Endocarditis, Rheumatic heart disease, Pacemaker, Heart valve shunt or stents, etc. **Please circle all that apply or explain**

._____

PLEASE CHECK ALL THAT APPLY

- ☐ Acid Reflux
- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis, Rheumatoid
- ☐ Artificial Joints
  When_____
  What joint_____
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally, with extractions or surgery
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Diabetes-type I, type II
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or Dizziness
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice/Liver Disease
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Low Blood Pressure
- ☐ Organ Transplant
- ☐ Radiation
- ☐ Respiratory Disease
- ☐ Sinus Trouble
- ☐ Smoker/Tobacco use
- ☐ Thyroid Problems
- ☐ Tuberculosis

Do you suffer from cold sores or canker sores? YES NO
Do you snore? YES NO Have you been diagnosed with Sleep Apnea? YES NO
Do you grind or clench? YES NO
Is there anything you would like to change about your smile? YES NO

To the best of my knowledge all of the preceding information is correct and if there is ever any change in health, or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider (s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper healthcare and treatment to be performed by this practice for the above named individual until further notice. I understand there are no guarantees or warranties in health or dental care.

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I authorize all insurance benefits be paid to Brett Blacher, DDS.

SIGNATURE_____ **DATE**_____
(Parent or guardian, if patient is a minor)