New Patient Registration

Thank you for selecting our dental office! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us – we will be happy to help!

Patient Information (Confidential)

Name_______________________________________Birthdate__________________SS#______________________

Address_______________________________________City______________State_______Zip_________________

Home Phone ______________________Work Phone __________________Cell Phone____________________

Fax Number _________________________ E-mail____

Check Appropriate Box ❑Minor ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Patient or Parent/Guardian's Employer ____

Business Address ___________________________City _____________State ______Zip_________________

Spouse or Parent/Guardian's Name____

Spouse or Parent/Guardian's Employer ____________________________Work Phone___________________

Whom may we thank for referring you? ____

Person to contact in case of emergency __________________________________Phone___________________

Responsible Party (If different from patient)

Name of Person Responsible for this account _________________________ Relationship _________________

Address ______________________________City ________________ State _______Zip _________________

Home Phone ___________________________ Work Phone __________________ Cell ___________________

Employer _______________________________________ E-mail _______________________________________

SS# ___________________________________ Is this person currently a patient in our office? ❑YES ❑NO

Insurance Information

Name of Policy Holder _______________________________________ Relationship _______________________

Birth date ___________________________ SS# __________________________ Date Employed ____________

Name of Employer ____ Work Phone ________________________

Employer Address __________________________________City _________ State ______ Zip ______________

Insurance Company ________________________________ Group # ___________ ID# ___________________

Ins Co. Address ____________________________________ City _________ State ______ Zip _______________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ❑ YES ❑ NO If yes, complete the following:

Name of Policy Holder _______________________________________ Relationship _______________________

Birth date ___________________________ SS# __________________________ Date Employed ____________

Name of Employer ____ Work Phone ________________________

Employer Address __________________________________City _________ State ______ Zip ______________

Insurance Company ________________________________ Group # ___________ ID# ___________________

Ins Co. Address ____________________________________ City _________ State ______ Zip _______________

Patient Medical History

Physician ______________________ Office Phone ___________________ Date of Last Exam ____________

1. Are you under medical treatment now? ❑YES ❑NO
2. Have you ever been hospitalized for any surgical or serious illness within the last 5 years? ❑YES ❑NO

   If yes, please explain ___________________________________

   ____

   ____

3. Are you taking any medications including non-prescription medicine? ❑YES ❑NO

   If yes, please explain ___________________________________

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4. Have you ever take Fen-Phen/Redux? ❑YES ❑NO
5. Do you use tobacco? ❑YES ❑NO
6. Do you use controlled substances? ❑YES ❑NO
7. Are you allergic to or have you had any reactions to the following? ❑YES ❑NO

   Local Anesthetics (e.g. Novocain)? ❑YES ❑NO

   Penicillin or any other antibiotics? ❑YES ❑NO

   Sulfa Drugs? ❑YES ❑NO

   Sedatives? ❑YES ❑NO

   Iodine? ❑YES ❑NO

   Aspirin? ❑YES ❑NO

   Any metals (e.g. nickel, mercury, etc.)? ❑YES ❑NO

   Latex Rubber? ❑YES ❑NO

   Other (Please List) _________________________________

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Women Only:

Are you pregnant or believe you may be pregnant? ❑YES ❑NO

Are you currently taking oral contraceptives? ❑YES ❑NO

Are you currently nursing? ❑YES ❑NO

Do you have, or have you had, any of the following?

AIDS/HIV Positive	❑YES ❑NO	Hemophilia	❑YES ❑NO
Alzheimer's Disease	❑YES ❑NO	Hepatitis A	❑YES ❑NO
Anaphylaxis	❑YES ❑NO	Hepatitis B or C	❑YES ❑NO
Anemia	❑YES ❑NO	Herpes	❑YES ❑NO
Angina	❑YES ❑NO	High Blood Pressure	❑YES ❑NO
Arthritis/Gout	❑YES ❑NO	Hives or Rash	❑YES ❑NO
Artificial Heart Valve	❑YES ❑NO	Hypoglycemia	❑YES ❑NO
Artificial Joint	❑YES ❑NO	Irregular Heartbeat	❑YES ❑NO
Asthma	❑YES ❑NO	Kidney Problems	❑YES ❑NO
Blood Disease	❑YES ❑NO	Leukemia	❑YES ❑NO
Blood Transfusion	❑YES ❑NO	Liver Disease	❑YES ❑NO
Breathing Problem	❑YES ❑NO	Low Blood Pressure	❑YES ❑NO
Bruise Easily	❑YES ❑NO	Lung Disease	❑YES ❑NO
Cancer	❑YES ❑NO	Mitral Valve Prolapse	❑YES ❑NO
Chemotherapy	❑YES ❑NO	Pain in Jaw Joints	❑YES ❑NO
Chest Pains	❑YES ❑NO	Parathyroid Disease	❑YES ❑NO
Cold Sores/Fever Blisters	❑YES ❑NO	Psychiatric Care	❑YES ❑NO
Congenital Heart Disorder	❑YES ❑NO	Radiation Treatments	❑YES ❑NO
Convulsions	❑YES ❑NO	Recent Weight Loss	❑YES ❑NO
Cortisone Medicine	❑YES ❑NO	Renal Dialysis	❑YES ❑NO
Diabetes	❑YES ❑NO	Rheumatic Fever	❑YES ❑NO
Drug Addiction	❑YES ❑NO	Rheumatism	❑YES ❑NO
Easily Winded	❑YES ❑NO	Scarlet Fever	❑YES ❑NO
Emphysema	❑YES ❑NO	Shingles	❑YES ❑NO
Epilepsy or Seizures	❑YES ❑NO	Sickle Cell Disease	❑YES ❑NO
Excessive Bleeding	❑YES ❑NO	Sinus Trouble	❑YES ❑NO
Excessive Thirst	❑YES ❑NO	Spina Bifida	❑YES ❑NO
Fainting Spells/Dizziness	❑YES ❑NO	Stomach/Intestinal Disease	❑YES ❑NO
Frequent Cough	❑YES ❑NO	Stroke	❑YES ❑NO
Frequent Diarrhea	❑YES ❑NO	Swelling of Limbs	❑YES ❑NO
Frequent Headaches	❑YES ❑NO	Thyroid Disease	❑YES ❑NO
Genital Herpes	❑YES ❑NO	Tonsillitis	❑YES ❑NO
Glaucoma	❑YES ❑NO	Tuberculosis	❑YES ❑NO
Hay Fever	❑YES ❑NO	Tumors or Growths	❑YES ❑NO
Heart Attack/Failure	❑YES ❑NO	Ulcers	❑YES ❑NO
Heart Murmur	❑YES ❑NO	Venereal Disease	❑YES ❑NO
Heart Pace Maker	❑YES ❑NO	Yellow Jaundice	❑YES ❑NO
Heart Trouble/Disease	❑YES ❑NO		

Have you ever had any serious illness not listed above? ❑YES ❑NO

If yes please explain:

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Patient Dental History

Do your gums bleed while brushing or flossing?	❑YES ❑NO
Are your teeth sensitive to hot or cold?	❑YES ❑NO
Are your teeth sensitive to sweet or sour?	❑YES ❑NO
Do you feel pain to any of your teeth?	❑YES ❑NO
Do you have any sore/lumps in/near your mouth?	❑YES ❑NO
Have you had any head, neck, or jaw injuries?	❑YES ❑NO
Have you ever experienced any of the following problems in your jaw?	❑YES ❑NO
Do you have frequent headaches?	❑YES ❑NO
Do you clench or grind your teeth?	❑YES ❑NO
Have you ever had any difficult extractions in the past?	❑YES ❑NO
Have you ever had any prolonged bleeding following extractions?	❑YES ❑NO
Have you had orthodontic treatment?	❑YES ❑NO
Do you wear dentures/partials? If yes, date of placement ___________	❑YES ❑NO
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	❑YES ❑NO
Do you like your smile?	❑YES ❑NO

Have you ever experienced any of the following problems in your jaw?

Clicking	❑YES ❑NO
Pain (joint, ear, side of face)	❑YES ❑NO
Difficulty in opening/closing?	❑YES ❑NO
Difficulty in chewing?	❑YES ❑NO

Authorization and Release

I certify that the above information is accurate and complete to the best of my knowledge. I understand that providing incorrect information can dangerous to my health. I will not hold Dr. Richard Papp or any member of the Westfields Dental staff responsible for any errors or omissions that I may have made in the completion of this form. It is my responsibility to inform Westfields Dental if any changes in my health status. I authorize Westfields Dental to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Westfields Dental insurance benefits otherwise payable to me. I understand that y dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Any assistance in filing insurance claims granted by Westfields Dental is given strictly as a courtesy and implies no responsibility on their part for filing, follow-through or confirmation. If this account is placed for collection, I agree to pay all legal fees, court costs, and other expenses incurred in the collection of this account. I further agree to pay returned check charges of $25 per returned check.

Signature of patient (or parent/guardian if minor) ___________________________________

Date ________________