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)

Patient Name _____
First Middle Last

Address _____
Street City State Zip

Social Security Number _____ Email _____

Date of Birth	Age	Sex M / F	Height	Weight

Home Phone _____

Cell Phone _____

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 drugs during their life?
Marijuana, Heroin, Crack, Cocaine, Meth, any other illegal drug? ☐Yes ☐No (if yes, please circle drugs used)

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

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

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

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

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

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

Name of Patient's Dentist: _____ Office located in what city?: _____

Name of Patient's Physician: _____ Office located in what city?: _____

How did you hear about us? ☐Valpak ☐Money Mailer ☐Billboard ☐Dr. Referral ☐Friend/Family ☐Other _____
☐Internet ☐Radio ☐TV

The following questions should be answered by the individual responsible for accompanying the patient home today.

Name: _____ Age: ___ Relation to patient: _____

Address: _____

Cell Phone: _____

For Office Use Only:

☐Highlights ☐Insurance/Medicaid ☐Consent ☐Referral ☐DrLetter

Updated: Feb 13, 2011