THE SMILE PLACE

Middletown | Cornwall

PATIENT REGISTRATION

Today's Date _____ Date of Birth _____ Sex _____

Patient's Name _____ SS# _____
LAST FIRST M.I.

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cellular Phone _____ Business Phone _____

Patient E-Mail Address _____

Patient Employed By _____

Employer's Address _____ Work Phone _____

Who is financially responsible? (if not the patient) _____ Date of Birth _____ SS# _____

Relationship to Patient _____ Home Phone _____

Street Address _____
CITY STATE ZIP

Pharmacy Name and Address _____ Phone _____

PRIMARY DENTAL INSURANCE	PRIMARY MEDICAL INSURANCE
Insurance Co. _____	Insurance Co. _____
Claims Address _____	Claims Address _____
_____	_____
Subscriber's Name _____	Subscriber's Name _____
Relationship to Patient _____	Relationship to Patient _____
Date of Birth _____ SS# _____ Sex _____	Date of Birth _____ SS# _____ Sex _____
ID# _____ Group # _____	ID# _____ Group # _____
SECONDARY DENTAL INSURANCE	**SECONDARY MEDICAL INSURANCE**
Insurance Co. _____	Insurance Co. _____
Claims Address _____	Claims Address _____
_____	_____
Subscriber's Name _____	Subscriber's Name _____
Relationship to Patient _____	Relationship to Patient _____
Date of Birth _____ SS# _____ Sex _____	Date of Birth _____ SS# _____ Sex _____
ID# _____ Group # _____	ID# _____ Group # _____

HEALTH HISTORY **Please Note – All information is held in strict confidence.**

Referring Dentist _____ Phone # _____

Referring Orthodontist _____ Phone # _____

Referring Doctor _____ Phone # _____

Family Physician _____ Phone # _____

What brings you to our office today? _____

Emergency Contact _____ Phone # _____

Are you presently under a physician's care? YES ☐ NO ☐

If Yes, what is the condition being treated?

Have any of your immediate family members been treated in our office? YES ☐ NO ☐

***Have you taken aspirin or NSAID's within the last 7 days? YES ☐ NO ☐**

Please list all medications you are now taking:

Medication	Dosage	Why

LIST ALL MEDICATIONS OR FOODS YOU ARE ALLERGIC TO:

Penicillin ☐ Sulfa ☐ Aspirin ☐

Codeine ☐ Novocaine ☐ Latex ☐

Are You Allergic To:

Eggs Yes ☐ No ☐

Soy Yes ☐ No ☐

Others

HABITS – AMOUNTS

Smoke ☐ _____ Packs

Alcohol ☐ _____ Per Day

Drug Use ☐ _____

Have you ever had a problem with drugs or alcohol?

Yes ☐ No ☐

Other