Patient Registration

First Name: Last Name: Preferred Name:

Date of Birth: Age: ○ Male ○ Female

Address: | City: | State: | Zip:

Email: | Cell Phone/Home: ( ) | Text? Yes / No

Marital Status: ○ Married ○ Single ○ Divorced ○ Separated Widowed

Reason for this visit:

How did you hear about Frontier Family Dentistry? ○ Facebook ○ Google ○ Other(describe)

Last Dental Visit: | Previous Dentist:

Emergency Contact Name:

Relationship: Phone Number: ( )

Responsible Party: ○ Self ○ If Different...

First Name: | Last Name: | Relationship to patient:

Address: City: State: Zip:

Phone Number: ( )

If you could change anything about your smile, what would it be? ________________________________

Are you interested in Clear Aligner Therapy? ○ Yes ○ No

Do you have dental insurance? ○ Yes ○ No

Subscriber's Name: | Birth Date: / /

SS#: | Insurance Company: | Employer:

Are you covered under more than one plan? ○ Yes ○ No

I hereby assign directly to Frontier Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I certify that the information that I have provided is true and correct to the best of my knowledge. I agree to inform Frontier Family Dentistry of any changes in my health status or the above information.

____ ____________________

Signature of Patient, Guardian or Personal Representative Date:

*For Doctor Only: ________________________

Health History

Physician's Name: ______________________________ Date of Last Visit: _____________________

Have you had and serious illnesses or operations? If yes, describe

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Have you ever been told to take antibiotics before a dental procedure? O Yes O No

Women: Are you Pregnant? O Yes O No Nursing? O Yes O No

Taking birth control pills? O Yes O No

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

O Acid Reflux/GERD	O Circulatory Problems	O Hepatitis	O Snoring/Sleep Apnea
O Anemia	O Cortisone Treatments	O High Blood Pressure	O Shortness of Breath
O Arthritis, Rheumatism	O Cough, Persistent	O HIV/Aids	O Skin Rash
O Artificial Heart Valves	O Diabetes	O Jaw Pain	O Stroke
O Artificial Joints	O Epilepsy	O Kidney Disease	O Swelling of Feet or Ankles
O Asthma	O Fainting	O Liver Disease	O Thyroid Problems
O Back Problems	O Glaucoma	O Mitral Valve Prolapse	O Tobacco Habit
O Blood Disease	O Headaches	O Pacemaker	O Tonsillitis
O Cancer	O Heart Murmur	O Radiation Treatment	O Tuberculosis
O Chemical Dependency	O Heart Problems	O Respiratory Disease	O Ulcer
O Chemotherapy	O Hemophilia	O Rheumatic Fever	O Venereal Disease

List Medications you are currently taking: ___________

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Pharmacy: _____________________________________

Allergies:

O Aspirin O Penicillin O Sulfa O Latex

O Barbiturates (Sleeping pills) O Codeine

O Other________________________________

____ _____________________

Signature of Patient, Guardian or Personal Representative Date: