NOA DENTAL

PATIENT REGISTRATION

Patient Information

First Name: ______________________ Last Name: ______________________ Middle Initial ____
Preferred Name: ______________________

Address: ______________________ Address 2: ______________________
City: ______________________ State, Zip: ______________________
Home Phone: ______________ Work Phone: ______________ Ext: ________ Cellular: ______________
Sex: ○ Male ○ Female Marital Status: ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed
Birth Date: ______________ Age: ______________ Soc Sec: ______________
Email: ______________________ □ I would like to receive correspondences via email

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired
Student Status: ○ Full Time ○ Part Time
Medicaid ID: ______________ Preferred. Dentist: ______________
Employer ID: ______________ Pref. Hygienist: ______________
Carrier ID: ______________ Pref. Pharmacy: ______________

Section 3

Emergency Contact: ______________________
Contact's Phone: ______________________
Other Address: ______________________
Other Address 2: ______________________
Physician Name: ______________________
Physician #: ______________________

Responsible Party Information (If someone other than the patient)

First Name: ______________________ Last Name: ______________________ Middle Initial ____
Address: ______________________ Address 2: ______________________
City, State, Zip: ______________________ Home Phone: ______________________
Work Phone: ______________________ Ext: ________ Cellular: ______________________
Birth Date: ______________________ Soc Sec: ______________________

○ Responsible Party is Also Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Primary Insurance Information

Name of insured: ______________________ Relationship to insured: ○ Self ○ Spouse ○ Child ○ Other
Insured Soc. Sec: ______________________ Insured Birth Date: ______________________
Employer: ______________________
Address: ______________________
Address 2: ______________________
City, State, Zip: ______________________
Rem. Benefits: ______________ Rem. Deductible: ______________

Insurance Company: ______________________
Address: ______________________
Address 2: ______________________
City: ______________________
State, Zip: ______________________

Secondary Insurance Information (if applicable)

Name of insured: ______________________ Relationship to insured: ○ Self ○ Spouse ○ Child ○ Other
Insured Soc. Sec: ______________________ Insured Birth Date: ______________________
Employer: ______________________
Address: ______________________
Address 2: ______________________
City, State, Zip: ______________________
Rem. Benefits: ______________ Rem. Deductible: ______________

Insurance Company: ______________________
Address: ______________________
Address 2: ______________________
City: ______________________
State, Zip: ______________________

Preferred Contact Method: home phone/ cell phone, text/ email   Ok to text cell phone? Yes / No   OK to email? Yes / No

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MEDICAL HISTORY

NAME: ______________________________ DATE: ______________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health conditions that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for your answers to the following questions.

Are you under a physician's care now? ○ Yes ○ No If yes, please explain: ____________
Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain: ____________
Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: ____________
Are you taking any medications, pills, or drugs? ○ Yes ○ No ____________
Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No ____________
Are you on a special diet? ○ Yes ○ No ____________
Do you use tobacco? ○ Yes ○ No
Do you use controlled substances? ○ Yes ○ No

Women: Are you
☐ Pregnant/Trying to get pregnant? ☐ Nursing?
☐ Taking oral contraceptives?

Are you Allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: ____________

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

☐ AIDS/HIV Positive
☐ Alzheimer's Disease
☐ Anaphylaxis
☐ Anemia
☐ Angina
☐ Arthritis/Gout
☐ Artificial Heart Valve
☐ Artificial Joint
☐ Asthma
☐ Blood Disease
☐ Blood Transfusion
☐ Breathing Problem
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Chest Pains
☐ Cold Sores/Fever
☐ Blisters
☐ Congenital Heart Disorder
☐ Convulsions
☐ Cortisone Medicine
☐ Diabetes
☐ Drug Addiction
☐ Easily Winded
☐ Emphysema
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Excessive Thirst
☐ Fainting Spells/ Dizziness
☐ Frequent Cough
☐ Frequent Diarrhea
☐ Frequent Headaches
☐ Genital Herpes
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack/Failure
☐ Heart Murmur
☐ Heart Pace Maker
☐ Heart Trouble / Disease
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B or C
☐ Herpes
☐ High Blood Pressure
☐ Hives or Rash
☐ Hypoglycemia
☐ Irregular Heartbeat
☐ Kidney Problems
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Pain in Jaw Joints
☐ Parathyroid Disease
☐ Psychiatric Care
☐ Radiation Treatments
☐ Recent Weight Loss
☐ Renal Dialysis
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Spina Bifida
☐ Stomach/Intestinal Disease
☐ Stroke
☐ Swelling of Limbs
☐ Thyroid Disease
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers
☐ Venereal Disease
☐ Yellow Jaundice
☐ None

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes, please explain: ____________

How did you hear about us? ❑Google ❑Yelp ❑Facebook ❑Instagram ❑Postcard ❑Santa Clarita Magazine ❑Phonebook ❑Walk-by ❑Insurance Network ❑Referral – Who shall we thank for your referral? ____________
❑Other: ____________
Comments: ____________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. -

SIGNTURE OF PATIENT, PARENT, or GUARDIAN ____________ **DATE** ____________