



Lori M. Trembath, DDS, PC
Family Dentistry
NEW PATIENT REGISTRATION FORM

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____
 Patient Is: Policy Holder Responsible Party Preferred Name: _____
 Address: _____ Address (Second Line): _____
 City: _____ State/Zip: _____
 Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____ Ext: _____
 Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
 Birth Date: _____ Age: _____ SSN: _____ Drivers License: _____
 Email: _____ I would like to receive correspondences via email: Yes No
 Employment Status: Full Time Part Time Contract Retired Other
 Student Status: Full Time Part Time Not Applicable
 Referred By: _____ Previous Dentist: _____
 Emergency Contact Name: _____ Emergency Contact Phone Number: (____) _____

Responsible Party (If someone other than patient)

First Name: _____ Last Name: _____ Middle Initial: _____
 Address: _____ Address (Second Line): _____
 City: _____ State/Zip: _____
 Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____ Ext: _____
 Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
 Birth Date: _____ Age: _____ SSN: _____ Drivers License: _____
 Email: _____ I would like to receive correspondences via email: Yes No
 Responsible Party is also a 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 SSN: _____ Insured Birth Date: _____
 Employer: _____ Insurance Co.: _____
 Address: _____ Address: _____
 Address (Second Line): _____ Address (Second Line): _____
 City, State/ Zip: _____ City, State/ Zip: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
 Insured SSN: _____ Insured Birth Date: _____
 Employer: _____ Insurance Co.: _____
 Address: _____ Address: _____
 Address (Second Line): _____ Address (Second Line): _____
 City, State/ Zip: _____ City, State/ Zip: _____



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MEDICAL HISTORY FORM

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

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

Women

Are you pregnant/ trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

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

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

Comments and Signature

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.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN: _____

DATE: _____