Woodholme SMILE CARE
YOUR HOME FOR DENTAL IMPLANTS AND ADVANCED DENTAL CARE
NEW PATIENTS WELCOME

Patient Registration

PATIENT INFORMATION

First Name		**Middle Initial**		**Last Name**			
Nickname		**Gender**	❑ Male ❑ Female	**Birth Date**		**Age**	
Social Security #		**E-mail**					
Address		**City**		**State**		**ZIP Code**	
Home Phone		**Cell Phone**					
Marital Status	❑ Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single						

WHO CAN WE THANK FOR REFERRING YOU TO OUR PRACTICE?

❑ Current Patient ❑ Referring Doctor ❑ Internet ❑ Insurance ❑ Other: _____

Referral Name	

RESPONSIBLE PARTY (if self is selected, please skip to the next section)

❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other: _____

First Name		**Last Name**		**Social Security #**			
Birth Date		**Age**		**Telephone**			
Address		**City**		**State**		**ZIP Code**	
Employer		**Business Telephone**					

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE COMPANY						SECONDARY DENTAL INSURANCE COMPANY					
Primary Policy Holder	First	Last				**Primary Policy Holder**	First	Last			
Relation		**Gender**	❑ Male ❑ Female			**Relation**		**Gender**	❑ Male ❑ Female		
S.S. #		**Birth Date**				**S.S. #**		**Birth Date**			
Address						**Address**					
City		**State**		**ZIP Code**		**City**		**State**		**ZIP Code**	
Telephone						**Telephone**					
Primary Policy Holder Employer						**Primary Policy Holder Employer**					
Insurance Co. Name						**Insurance Co. Name**					
Address						**Address**					
City		**State**		**ZIP Code**		**City**		**State**		**ZIP Code**	
Telephone						**Telephone**					
Group #		**Policy ID #**				**Group #**		**Policy ID #**			

EMERGENCY CONTACT

First Name		**Last Name**	
Telephone		**Relationship to Patient**	

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HEALTH HISTORY

Height		**Weight**			
Are you under the care of a physician? If yes, please complete the line below.				❑ Yes	❑ No
Date of Last Visit		**Physician Name**		**Physician Phone**	
Preferred Pharmacy		**Pharmacy Location**		**Pharmacy Phone**	
Have you had any recent or scheduled surgeries?				❑ Yes	❑ No
If yes, please describe					
Do you smoke or use tobacco?				❑ Yes	❑ No
Are you taking Bisphosphonates?				❑ Yes	❑ No
How long?		❑ Oral ❑ Injectable ❑ IV	**Last treatment date?**		

FOR WOMEN ONLY

Are you pregnant?	❑ Yes ❑ No	**If yes, number of weeks**	
Are you nursing?	❑ Yes ❑ No	**Are you taking birth control pills?**	❑ Yes ❑ No

WARNING: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician for assistance regarding additional methods of birth control.

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

	Yes	No		Yes	No		Yes	No
Abnormal Bleeding			**Emphysema**			**Mitral Valve Prolapse**		
Alcohol Abuse			**Epilepsy**			**Osteoporosis**		
Allergies			**Fainting Spells**			**Pace Maker**		
Anemia			**Fever Blisters**			**Psychiatric Problems**		
Angina Pectoris			**Glaucoma**			**Radiation Therapy**		
Artificial Bones			**HIV+ AIDS**			**Rheumatic Fever**		
Artificial Heart Valve			**Heart Attack**			**Seizures**		
Artificial Joints			**Heart Surgery**			**Shingles**		
Asthma			**Hemophilia**			**Sickle Cell Disease**		
Blood Transfusion			**Hepatitis**			**Stroke**		
Cancer - Chemotherapy			**High Blood Pressure**			**Thyroid Problems**		
Congenital Heart Defect			**High Cholesterol**			**Tuberculosis**		
Diabetes			**Kidney Problems**			**Ulcers**		
Difficulty Breathing			**Liver Disease**			**Yellow Jaundice**		
Drug Abuse			**Low Blood Pressure**					

Is there any disease, condition, or problem that you think our office should know about that is not listed above? If yes, please list below.

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MEDICATIONS

Please list all medications, over the counter and herbal supplements, that you are currently taking (include medication name, dosage and frequency):

ALLERGIES/REACTIONS

Are you allergic to, or had a reaction to any of the following?

	Yes	No		Yes	No
Aspirin			**Codeine**		
Dental Anesthetics			**Erythromycin**		
Jewelry			**Latex**		
Metals			**Penicillin**		
Tetracycline			**Other**		

Please list any allergy/reaction that you have or have had that is not listed above.

ADDITIONAL NOTES/COMMENTS

FORM COMPLETION

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.

There may be an increased risk of COVID -19 exposures at this time. I also understand it is possible to be exposed to COVID during any appointment that includes close human contact. I understand I may have been exposed to COVID at any time prior to my treatment at this office.

Signature of	❑ Patient ❑ Legal Guardian	❑ Parent ❑ Agent Under Durable Power of Attorney
Printed Name	*First Name*	*Last Name*
Signature of Patient, Parent or Guardian		**Date**