Morris Dental

Welcome! Our team of experienced dental professionals is committed to providing you with personalized care that prioritizes your smile and oral health.

New Patient Registration Form **(Please Print)**

Date_____

Patient Information

Name:	DOB:	SSN#:
Marital Status (please circle): Minor Single Married Divorced Separated Widowed		
Address:		City, State:
		Zip Code:
Occupation:	Employer:	
Employer Address:		
Preferred Phone #:	Alternate Phone #:	
Email Address:		
Preferred Method of Communication (please circle): Phone Call Text Cell #_____ Email		
Emergency Contact Name:	Relationship to Patient:	
Phone #:	Alternate Phone #:	
Whom may we thank for referring you?		

Responsible Party

Name:	DOB:	SSN#:
Relationship to Patient:	Is this person a patient here?	
Marital Status (please circle): Minor Single Married Divorced Separated Widowed		
Address:		City, State:
		Zip Code:
Occupation:	Employer:	
Employer Address:		
Preferred Phone #:	Alternate Phone #:	
Email Address:		
Preferred Method of Communication (please circle): Phone Call Text Cell #_____ Email		

Insurance Information (Please be prepared to give your insurance card to the receptionist.)

Primary Insurance

Name of Insured:	DOB:	SSN#:
Relationship to Patient:	Is this person a patient here?	
Occupation	Employer	
Employer Address:		City, State:
		Zip Code:
Primary Insurance Co.:		
Group #:	Policy/ID #:	

Secondary Insurance (if applicable)

Name of Insured:	DOB:	SSN#:
Relationship to Patient:	Is this person a patient here?	
Occupation	Employer	
Employer Address:		City, State:
		Zip Code:
Secondary Insurance Co.:		
Group #:	Policy/ID #:	

Patient Medical History (Confidential)

Physician: Office Phone: Date of Last Exam:

Please circle the appropriate answer.

1. Are you under medical treatment now?	Yes	No	6. Do you use controlled substances?	Yes	No
2. Have you been hospitalized for any surgical operation or serious illness within the last 5 years?	Yes	No	7. Do you wear contact lenses?	Yes	No
If yes please explain:			8. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	Yes	No
3. Are you taking any medication(s) including non-prescription medicine?	Yes	No	9. Women only:	Yes	No
If yes, what medication(s)?			a) Are you pregnant or think you may be pregnant?	Yes	No
4. Have you ever taken Fen-Phen/Redux?	Yes	No	b) Are you nursing?	Yes	No
5. Do you use tobacco?	Yes	No	c) Are you taking oral contraceptives?	Yes	No

10. Are you allergic to or have you had any reactions to the following?					
Local Anesthetics (e.g. Novocain)	Yes	No	Penicillin or any other Antibiotics	Yes	No
If yes, please specify:			If yes, please specify:		
Sulfa Drugs	Yes	No	Barbiturates	Yes	No
If yes, please specify:			If yes, please specify:		
Sedatives	Yes	No	Any Metals (e.g. nickel)	Yes	No
If yes, please specify:			If yes, please specify:		
Iodine	Yes	No	Aspirin	Yes	No
Latex Rubber	Yes	No	Codeine	Yes	No
Please list any other allergies:					

11. Do you have or have you had any of the following?								
High Blood Pressure	Yes	No	Heart Disease	Yes	No	Sexually Transmitted Disease	Yes	No
Heart Attack	Yes	No	Cardiac Pacemaker	Yes	No	Stomach Troubles/Ulcers	Yes	No
Rheumatic Fever	Yes	No	Heart Murmur	Yes	No	Chest Pains	Yes	No
Swollen Ankles	Yes	No	Angina	Yes	No	Easily Winded	Yes	No
Fainting/Seizures	Yes	No	Mitral Valve Prolapse	Yes	No	Stroke	Yes	No
Asthma	Yes	No	Other Heart Condition	Yes	No	Hay Fever/Allergies	Yes	No
Low Blood Pressure	Yes	No	Frequently Tired	Yes	No	Tuberculosis	Yes	No
Epilepsy/Convulsions	Yes	No	Anemia	Yes	No	Radiation Therapy	Yes	No
Leukemia	Yes	No	Emphysema	Yes	No	Glaucoma	Yes	No
Diabetes	Yes	No	Cancer	Yes	No	Recent Weight Loss	Yes	No
Kidney Diseases	Yes	No	Arthritis	Yes	No	Liver Disease	Yes	No
AIDS or HIV Infection	Yes	No	Joint Replacement or Implant	Yes	No	Respiratory Problems	Yes	No
Thyroid Problem	Yes	No	Hepatitis/Jaundice	Yes	No	Dizziness/Nausea	Yes	No
Other (please list)								

Patient Dental History (Confidential)

Previous Dentist and Location: Date of Last Exam:

Please circle the appropriate answer.

1. Do your gums bleed while brushing or flossing?	Yes	No	10. Have you ever had any difficult extractions in the past?	Yes	No
2. Are your teeth sensitive to hot or cold liquids/foods?	Yes	No	11. Have you ever had any prolonged bleeding following extractions?	Yes	No
3. Are your teeth sensitive to sweet or sour liquids/foods?	Yes	No	12. Have you had any orthodontic treatment?	Yes	No
4. Do you feel pain in any of your teeth?	Yes	No	13. Do you wear dentures or partials?	Yes	No
5. Do you have any sores or lumps in or near your mouth?	Yes	No	14. Have you ever experiences any of the following problems in your jaw?		
6. Have you had any head, neck, or jaw injuries?	Yes	No	Clicking	Yes	No
7. Do you have frequent headaches?	Yes	No	Pain (joint, ear, side of face)	Yes	No
8. Do you clench or grind your teeth?	Yes	No	Difficulty in opening or closing	Yes	No
9. Do you bite your lips or cheeks frequently?	Yes	No	Difficulty in chewing	Yes	No

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ _____

Signature of patient (or parent/guardian if minor) Date

Doctor's comments:

X_____ _____

Signature of Doctor Date

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