



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.

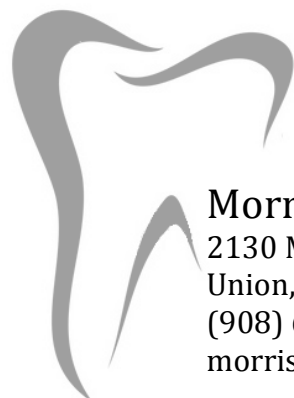
X _____
Signature of patient (or parent/guardian if minor)

Date

Doctor's comments:

X _____
Signature of Doctor

Date



Morris Dental
2130 Morris Ave.
Union, NJ 07083
(908) 688-2484
morrisdentalnj.com