Office Use Patient ID#_____

New Patient Registration Form

Welcome to *Ascot Aesthetic* Implants & Dentistry

Date: _____

Patient's Name_____ **SSN#**_____
Title (Please check one) **Mr.** □ **Mrs.** □ **Ms.** □ **Miss** □ **Dr.** □ **Rev.** □ Other □_____
Marital Status: (Please check one) **Single** ☑ **Married** □ **Divorced** □ **Widowed** □

Gender: Male □ Female □ **Date of Birth:** Month _____Day _____Year _____ Driver License#_____

Address_____**City**_____**State**_____**Zip Code**_____

Home#_____ **Cell#**_____ **Work#**_____

Email Address _____
Consent to receive emails, text, and/or Post Cards for appointment reminders:
Email: Yes □ No □ **Text Messages:** Yes □ No □ **Recall Post Cards:** Yes □ No □

Emergency Contact: _____**Relationship**_____**Phone**_____

Insurance: Yes □ or No □ **Self Pay:** Yes □ or No □ **** (If Self Pay skip to Patient Medical History) ****

Subscriber Information: Check One: Self____ Spouse____ Other_____

Relationship to Subscriber: Check One: Self___ Spouse___ Child ____ Other_____
Subscriber's Name_____ **DOB**_____**SSN#**_____

Address_____**City**_____**State**____ **Zip Code**_____

Employed By_____ **Employer's Address**_____

Home#_____ **Cell#**_____ **Work#**_____

**********Patient Medical History**********

Physician's Name_____

Date of last physical _____ Office Phone #_____ Office Fax # _____

1. Are you in general good health at this time? **Yes**□ **No**□

2. Are you under any medical treatment now? If so, for what condition(s)?_____
_____

3. Do you have a history of fainting or seizures?**Yes**□ **No**□ Have you had joint replacement surgery**? Yes** □ **No**
If Yes, when? _____
Have you had any major operations? If so, what? _____

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5. Have you ever had any abnormal bleeding, or required a blood transfusion? **Yes** □ **No** □
6. Do you have a history of drug or alcohol abuse? **Yes** □ **No** □
7. Are you under Pain Management Program? **Yes** □ **No** □ If Yes, Name of Provider_____
Provider's Phone#_____
8. Do you use tobacco products? **Yes** □ **No** □
Type of product_____ How much daily _____ For how long? _____
9. Have you ever had one of the following:

	Yes	or **No**
Prosthetic Cardiac Valve (including palliative shunts & conduits)	□	□
Cardiac Transplant	□	□
Previous Infective Endocarditis	□	□
Orthopedic surgery with joint prosthetic replacement?	□	□

10. Has a physician ever informed you that you have: **Please answer Yes or No**

Cardiovascular Disease _____ Stroke _____ High Blood Pressure _____

Neurological Disease _____ Diabetes _____ Growths or Tumors _____

Thyroid Problems _____ Sinus Problems _____ Asthma _____

Liver Disease _____ Kidney Disease _____ Hepatitis _____

Stomach or Intestinal Disease_____ Tuberculosis _____ Emotional Problems _____

Aids of HIV Infections _____ Sexually Transmitted Disease _____

11. Do you have any known Drug Allergies **Yes** □ **No** □
or are you allergic to, or have you ever reacted adversely to: **If yes, what type of reaction (rash, SOB,)**

Local Anesthetic (such as Novocain)? _____ Aspirin of Codeine? _____

Penicillin, sulfa drugs, or other antibiotics? _____ Barbiturates, sedatives or sleeping pills? _____

Latex _____Other _____

12. Have you been diagnosed with Sleep Apnea? **Yes** □ **No** □ Do you use a CPAP machine or any other oral mandibular advancement device? **Yes** □ **No** □

13. Please list any medications you are **currently** taking. _____

_____

Pharmacy: _____Location: _____Phone_____

14. Are there any medical or dental conditions you feel your dentist should know before starting your dental treatment? If so, please explain_____

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15. Are you Pregnant? **Yes** □ **No** □ Nursing? **Yes** □ **No** □ Taking Oral Contraceptives? **Yes** □ **No** □

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**Note: While being a patient in our practice, Dr. Ruff may find it necessary to prescribe an antibiotic to fight off an existing dental infection or to prevent possible infection during a dental procedure. If you are taking oral contraceptives (birth control pills), additional contraceptive measures are recommended while taking antibiotics and for a period of time following the course of antibiotic therapy. Please follow the instructions that were enclosed with your BCP pack or call your physician or pharmacist for specific instructions. **

Name: _____DOB:_____Date:_____

16. Have you had sedation for past dental care? If so, what type_____
Nitrous Oxide □ Oral Sedation □ Intravenous □

17. Are you interested in sedation for future dental treatment? _____

18. Do you have difficulty with strong gag reflex? **Yes** □ **No** □

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ **Date_____**
(Signature of Patient and/or Legal Guardian)

Medical History Update:

Date	Comments	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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