



# ADULT NEW PATIENT REGISTRATION FORM



Today's Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Name: \_\_\_\_\_  
 Male  Female Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ SS#: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Married  Single  Other  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 E mail: \_\_\_\_\_ Patient's Employer: \_\_\_\_\_  FT  
 PT College Student (College/Univ-Name/Town/State of College): \_\_\_\_\_  
 Who referred you? \_\_\_\_\_  Phone Book  Internet  Refer a Friend  
 Emergency Contact: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 H phone: \_\_\_\_\_ W phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

## PRIMARY DENTAL INSURANCE

Primary Insurance Company: \_\_\_\_\_  
 Primary Policyholder-Subscriber Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ **WE CAN PHOTOCOPY YOUR CARD**  
 Home Ph#: \_\_\_\_\_ Work Ph# \_\_\_\_\_ Cell Ph# \_\_\_\_\_  
 DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ SS#: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Group#: \_\_\_\_\_ ID#: \_\_\_\_\_  
 Employer: \_\_\_\_\_

## SECONDARY DENTAL INSURANCE

Secondary Insurance Company: \_\_\_\_\_  
 Secondary Policyholder-Subscriber Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ **WE CAN PHOTOCOPY YOUR CARD**  
 Home Ph# \_\_\_\_\_ Work Ph#: \_\_\_\_\_ Cell Ph#: \_\_\_\_\_  
 DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ SS#: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Group#: \_\_\_\_\_ ID#: \_\_\_\_\_  
 Employer: \_\_\_\_\_

## ADULT CONSENT FOR TREATMENT:

I certify that the information that I have provided on this form is complete and accurate to the best of my knowledge. I understand that providing accurate information regarding my health allows Brink Street Dental, Ltd. to treat me effectively and safely. I understand that I am financially responsible for all charges whether they are covered by insurance or not. I authorize the clinical staff of Brink Street Dental, Ltd to perform necessary diagnostic dental services including, but not limited to x-rays, intraoral photographs and diagnostic models. I understand that I will be consulted as to all recommended treatment and alternatives before treatment is provided.

**X** \_\_\_\_\_ **X** \_\_\_\_\_  
 Date: \_\_\_\_\_ Signature of Insured: \_\_\_\_\_

## ASSIGNMENT OF BENEFITS TO INSURANCE:

I, the undersigned, have dental insurance coverage and request assignment of benefits to Dr. David Niles of Brink Street Dental, Ltd. I understand that the information given will be held in strict confidence. I hereby authorize the doctor to release all information necessary to secure the payment of benefits unless revoked. I authorize the signature on all insurance submission whether manual or electronic:

**X** \_\_\_\_\_ **X** \_\_\_\_\_  
 Date: \_\_\_\_\_ Signature of Insured: \_\_\_\_\_



# NEW PATIENT MEDICAL FORM



**Patient Name:** \_\_\_\_\_

## Health Information

**Do you have, or have you had any of the following? Please check those that apply**

**For both adults/child:**

<input type="checkbox"/> AIDS	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Allergies _____	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Smoker
<input type="checkbox"/> Anemia	<input type="checkbox"/> Hepatitis circle: (A,B,C)	# Cigarettes/Day _____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> High Blood Pressure	# Yrs Smoked _____
<input type="checkbox"/> <b>Artificial joints or implants?</b>	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Stomach Problems
Location of implant: _____	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Stroke
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Tumors
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mental or Nervous Disorders	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Codeine Allergy
<input type="checkbox"/> Excessive Bleeding	Due Date: ____/____/____	<input type="checkbox"/> Penicillin Allergy
<input type="checkbox"/> Fainting	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> OTHER: _____
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> Drug Allergies: _____
<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Rheumatic Fever	_____
	<input type="checkbox"/> Rheumatism	_____

**For our children patients (Check those that apply):**

- Measles yes/no,       chicken pox yes/no,
- Mononucleosis yes/no,       ADD/ADHD yes/no,
- Mumps yes/no,       Sinus Problems yes/no,
- Autism yes/no,       Artificial limb/metal implant yes/no

Current Medications: \_\_\_\_\_

- Have you ever had any complications following dental treatment?     Yes     No  
If yes, please explain: \_\_\_\_\_
- Have you been admitted to a hospital or needed emergency care during the past two years?     Yes     No  
If yes, please explain: \_\_\_\_\_
- Are you now under the care of a physician?     Yes     No  
If yes, please explain: \_\_\_\_\_
- Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_
- Do you have any health problems that need further clarification?     Yes     No    If yes, please explain: \_\_\_\_\_



# NEW PATIENT DENTAL FORM



## Dental Information

Do you have, or have you had any of the following? Please check all those that apply

For both adults and children:

<input type="checkbox"/> Do you have sensitive gums?	<input type="checkbox"/> Allergy to Antibiotics? (i.e. penicillin)
<input type="checkbox"/> Do you have headaches?	<input type="checkbox"/> Allergy to Iodine?
<input type="checkbox"/> Are your teeth sensitive to hot/cold?	<input type="checkbox"/> Allergies to Sulfa drugs?
<input type="checkbox"/> Have you had difficult extractions in the past?	<input type="checkbox"/> Allergic to Sedatives?
<input type="checkbox"/> Do you grind your teeth?	<input type="checkbox"/> Allergic to Barbiturates?
<input type="checkbox"/> Have you had a previous negative dental experience?	<input type="checkbox"/> Allergic to metals (i.e. nickel, mercury?)
<input type="checkbox"/> Do you floss regularly?	<input type="checkbox"/> Allergic to Aspirin?
<input type="checkbox"/> Have you a negative reaction to Novocain?	<input type="checkbox"/> Allergic to Latex Rubber?

### For our children patients:

Does your child have a habit of: Lip Sucking/Biting?

Does your child have a habit of Nail Biting?

Does your child have a habit of Thumb/Finger Sucking?

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

X

Signature of patient, parent or guardian

X

Date: