CHRISTOPHER G. STUZYNSKI, D.D.S.

NEW PATIENT REGISTRATION FORM

Patient Information

Patient Name	
Date of Birth	
Gender	Male Female
Marital Status	Single Married Divorced Separated
Social Security Number	
Cell Phone	

:

Home Address: _____

City, State, Zip: _____

Driver's License & State: _____

Insurance Information

Primary Insurance Company:	
Policy Holder Name:	
Policy/ID Number:	
Group Number	

Secondary Insurance (if applicable): _____

Dental History

Previous Dentist: _____ Last Visit: _____ Date of Last Cleaning: _____

Reason for Visit Today: _____

How often do you brush? _____ Do you floss? Yes No

Please check any that apply:

- Clench/grind teeth
- Want teeth straightened
- Gums bleed when brushing/flossing
- Had orthodontics
- Facial/jaw injury
- Gums tender/swollen
- Avoid brushing due to pain
- Want teeth whitened

Medical History

Overall, Health: Excellent Good Fair Poor

Please check any that apply:

- ☐ Congenital Heart Defect
- ☐ Heart Disease
- ☐ Asthma
- ☐ Arthritis
- ☐ Abnormal Bleeding
- ☐ Diabetes
- ☐ Cancer/Chemotherapy/Radiation
- ☐ High Blood Pressure

- ☐ Low Blood Pressure
- ☐ Epilepsy/Seizures
- ☐ Hepatitis: A B C
- ☐ Thyroid: High
- ☐ Thyroid: Low
- ☐ Stroke
- ☐ Pacemaker
- ☐ Organ Transplant
- ☐ Herpes
- ☐ Sexually Transmitted Disease
- ☐ HIV/AIDS
- ☐ History of Depression/Anxiety
- ☐ History of Drug Addiction/ Alcohol Abuse
- ☐ Are you taking birth control
- ☐ Are you or could you be pregnant or nursing
- ☐ Are you currently or have you ever taken Bisphosphonates
- ☐ Do you usually take an antibiotic before dental treatment
- ☐ Do you have any Implants/Artificial Joints if so, please list on line below:
  _____

Other medical problems not listed: _____

Allergies

· Aspirin

· Ibuprofen

· Sulfa Drugs

· Penicillin

· Codeine

· Latex/Metals/Plastics

· Local Anesthetics

· ☐ Other: _____

Current Medications

Medicine: _____ Medicine: _____
Medicine: _____ Medicine: _____
Medicine: _____ Medicine: _____

Emergency Contact

Name: _____ _____Relationship: _____ Phone: _____
Name: _____ _____Relationship: _____ Phone: _____

Signatures

Patient's Printed Name: _____Signature: _____ Date: _____
Doctor's Printed Name: _____ Signature: _____ Date: _____