Diane Bonanni, DMD
Family and Cosmetic Dentistry

New Patient Registration

Name of Patient:	Address:
E-mail	
Phone Number:	

Date of Birth:
Marital Status: ☐ Minor ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Emergency Contact

Emergency Contact: ____
Relationship of Emergency Contact:______________________________
Their Phone Number:____

Insurance Information

Name of Insured:	Name of Insurance:
Phone Number of Insured:	Insurance Group Number:
Relationship to Patient:	Insurance ID Number:
Name of Employer:	

Payment Option: ☐ Insurance ☐ Cash ☐ Credit Card ☐ Check ☐Office Plan

Health History

Previous Dentist

Name:
Last Dental Visit:
Last Cleaning:

Medical History

Name of Doctor:
Office Phone:
Last Medical Exam:

Do you have allergies or reactions to:

☐ None
☐ Local Anesthetic like Novocaine
☐ Penicillin or other Antibiotics
☐ Barbiturates Sedatives
☐ Iodine
☐ Aspirin
☐ Any metals like nickel or mercury
☐ Latex
☐ Other

Do you use recreational drugs? ☐ Yes ☐ No

Do you or have you ever smoked or used tobacco? Please describe type, frequency and duration

How often do you consume alcoholic beverages? ☐ Never ☐ Once a month ☐ 2-3 times a week ☐ Once a week ☐ Everyday

Are you currently pregnant or trying to become pregnant? ☐ Yes ☐ No ☐ N/A

Taking any medications, currently? ☐ Yes ☐ No

Any other information you would like us to know?

Dental Health

	Yes	No
Do you get food caught between your teeth?		
Do you have any missing teeth?		
Do your gums bleed?		
Do you floss regularly?		
Are your teeth hot/cold sensitive?		
Are your teeth sensitive to sweets?		
Teeth extracted?		
Do you clench or grind your teeth?		
Do you have a nightguard/bite splint?		
Have you ever had oral surgery?		
Do you have tired jaws?		
Do you have orthodontics/braces?		
Do you have popping or clicking in the jaw?		
Have you ever had a periodontal treatment?		
Do you chew on pens, fingernails, etc?		
Have you had any injuries to your face/jaw?		
Do you drink coffee, tea, or red wine?		
Do you wear dentures or partials?		
Do you like your smile?		

Do you have any other disease/condition not listed?

I, the above-named patient, understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Dr. Diane Bonanni has my permission to ask the respective health care provider or agency, who may release such information. I will notify this dental care facility of any and all changes in my health or medications. I consent to the performing of dental procedures agreed to be necessary or advisable, including the use of local anesthetics.

Patient Signature
Date

Parent Signature if Patient is Minor
Date
Date

Do you have, or had in the past, any of these conditions?

	Yes	No
Heart surgery, disease, attack?		
Blood transfusion?		
Heart murmur?		
Hemophilia or blood disorder?		
Mitral valve prolapse?		
Hepatitis A, B?		
Heart attack or strokes?		
Tuberculosis or lung disease?		
Artificial heart valve?		
Tumors?		
Heart pacemaker?		
Headaches or migraines?		
Artificial joints (hip, knee, etc)?		
Convulsions or epilepsy?		
Neurological disorders?		
Dizzy spells or fainting?		
Rheumatic fever?		
Cold sores or fever blisters?		
Diabetes?		
Thyroid disorder?		
Kidney disease?		
Stomach, intestinal, or colon disorders?		
Jaundice or liver disease?		
Cortisone or steroid therapy?		
High blood pressure?		
Possess the HIV or AIDS antibody?		
Low blood pressure?		
Psychiatric or psychological care?		
Cancer?		
Hay fever or airborne allergies?		
Radiation or Chemotherapy?		
Bruise easily?		
Emphysema or asthma?		
Venereal disease?		