

JONATHAN A. LEVEY, D.D.S.  
FAMILY DENTISTRY

PATIENT REGISTRATION FORM

Patient's Name \_\_\_\_\_ SSN# \_\_\_\_\_

Sex: Male \_\_\_\_\_ Female \_\_\_\_\_ Marital Status \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Student: Yes \_\_\_\_\_ No \_\_\_\_\_ Name of School \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Employer \_\_\_\_\_ SSN# \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Person financially responsible \_\_\_\_\_

Name of Primary Dental Insurance \_\_\_\_\_

Patient's relationship to the insured: Self Spouse Child Other

Address of Insurance Company \_\_\_\_\_

Name of the Insured \_\_\_\_\_ Insured's SSN# \_\_\_\_\_

Group/Policy # \_\_\_\_\_ Effective Date \_\_\_\_\_

Name of Secondary Dental Insurance \_\_\_\_\_

Patient's relationship to the insured: Self Spouse Child Other

Address of Secondary Insurance Company \_\_\_\_\_

Name of Insured \_\_\_\_\_ Insured's SSN# \_\_\_\_\_

Group/Policy # \_\_\_\_\_ Effective Date \_\_\_\_\_

In case of an emergency, call \_\_\_\_\_ Phone # \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Would you be interested in reminders by E-mail? Yes \_\_\_\_\_ No \_\_\_\_\_ Address \_\_\_\_\_

I authorize payment of all dental benefits directly to the attending dentist.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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MEDICAL HISTORY

Patient Name: \_\_\_\_\_
Physicians Name \_\_\_\_\_ Phone# \_\_\_\_\_
Date of last physical exam \_\_\_\_\_ Are you now under the care of a physician? Yes / No
If yes, please explain \_\_\_\_\_
Please list all medications currently being taken, including vitamins \_\_\_\_\_

ARE YOU ALLERGIC TO ANY MEDICATIONS? Yes / No
IF YES, WHICH ONES? \_\_\_\_\_

Do you smoke? Yes / No If yes, how many packs per day? \_\_\_\_\_ For how long? \_\_\_\_\_
Women: Could you be or are you pregnant? Yes / No
Are you taking birth control pill or female hormones? Yes / No

Have you ever had or now have:

Table with 4 columns: Condition, Yes/No, Condition, Yes/No. Rows include Hypoglycemia, Diabetes; Heart Attack or Heart Trouble; Hay Fever, Asthma, Allergies; High Blood Pressure; Circulatory Problems; Hepatitis, Jaundice; Lung Problems, Tuberculosis; Epilepsy, Seizures; Blood Transfusions; Facial or Head Injuries; Malignancies, Cancer; Sinus Problems; Joint Replacement/other Implants; AIDS/HIV Positive; OTHER; Stroke; Heart Murmur; Rheumatic Fever; Anemia, Blood Disorder; Excessive Bleeding; Fainting, Blackouts; Nervous Disorder; Headaches, Migraines; Kidney Problems; Glaucoma, Eye Problems; Ulcers; Alcohol or Chemical dependency; Autoimmune Disease.

Comments regarding any of the above conditions: \_\_\_\_\_

DENTAL HEALTH

Name of last dentist \_\_\_\_\_ Date of last X-rays \_\_\_\_\_

Have you ever thought about straightening you teeth? Yes/No ASK US ABOUT INVISALIGN

Do any of the following currently concern you?

Table with 4 columns: Condition, Yes/No, Condition, Yes/No. Rows include Teeth tender to chew on; Discomfort in face, head, neck; Food caught between teeth; Bleeding or sore gums; Sensitivity to sweets; Recurring oral sores; Jaw clicking or popping; Sensitivity to hot or cold; Swelling, lumps in mouth.

I CERTIFY THAT THE ABOVE INFORMATION IS CURRENT AND CORRECT AND THAT I WILL NOTIFY THIS OFFICE OF ANY CHANGES.

SIGNATURE OF PATIENT \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE OF DENTIST \_\_\_\_\_ DATE \_\_\_\_\_