Dr. Gregory A. Hillyard & Dr. Alexandra H. Monroe

NEW PATIENT REGISTRATION

Please PRINT all information. Thank you.

Name ______________________________ Mr. Mrs. Dr. Miss Ms. Date of Birth ______________
Address ______________________________ City ____________ State _____ Zip ____________
Email ______________________ Home Phone ______________ Cell ______________
Occupation ______________ Employer ______________ Work Phone ______________
Physician's Name ______________________ Physician's # ______________________
Emergency Contact ______________________ Relation ______________ Phone ______________
Marital Status ______________ Name of parent/guardian if patient is a minor: ______________
Preferred Method for Appointment Reminders: ☐ Text ☐ Email ☐ Home ☐ Cell
How did you hear about our office: ☐ Friend ☐ Google ☐ Office Sign ☐ Magazine ☐ Family ☐ Website
Other: ______________ Who may we thank for referring you? ______________________
Do you have Dental Insurance? ☐ Y ☐ N Name of Insurer: ______________________
If you would like us to submit claims on your behalf, please provide either your dental Insurance ID number ______________
or your social security number. ______________

1. Are you happy with your smile? ☐ Y ☐ N If not, why? ______________________
2. What is your present dental problem? ______________________
3. When was your last dental cleaning and exam? ______________ X-rays? ______________
4. Please list any MEDICATIONS or SUPPLEMENTS you are currently taking: ______________________
____
5. Do you have any allergies (Latex, food, Penicillin, drug, etc)? ☐ Y ☐ N Please list: ______________________
____
6. Have you ever had any unusual reactions to any medications? ☐ Y ☐ N Please explain: ______________________
7. Do you smoke? ☐ Y ☐ N Previously smoked? ☐ Y ☐ N If yes to either, for how long? ______________
Do you use any other forms of tobacco? ☐ Y ☐ N If yes, please explain: ______________________
8. Do you snore? ☐ Y ☐ N If yes, do you have a snore guard? ☐ Y ☐ N
9. Have you ever had cancer? ☐ Y ☐ N Type? ______________ Did you receive head and neck radiation? ☐ Y ☐ N
10. Have you ever been diagnosed with Osteoporosis? ☐ Y ☐ N Have you taken Bisphosphonates (Fosamax, Boniva, etc.)? ☐ Y ☐ N
11. Please list any hospitalizations, surgeries or major illnesses you have had: ______________________
____
12. Has any physician recommended you pre-medicate before dental treatment? ☐ Y ☐ N
Do you have any artificial heart valves? ☐ Y ☐ N Have you ever had a joint replaced? ☐ Y ☐ N
13. Are you allergic to any of the following:
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs
☐ Other Please explain: ______________________

WOMEN

Are you pregnant or trying to get pregnant? ☐ Y ☐ N Taking oral contraceptives? ☐ Y ☐ N Nursing? ☐ Y ☐ N

Gregory A. Hillyard, DMD & Alexandra H. Monroe, DMD
47 State Rd | Media | PA | 19063

Please indicate with an X in the box if you have, or have not had, any of the following medical conditions.

YES	NO		YES	NO		YES	NO		YES	NO	
		AIDS/HIV Positive			Congenital Heart Defect			Hemophilia			Pain in Jaw Joints
		Alzheimer's Disease			Diabetes			Hepatitis			Psychiatric Care
		Anemia			Drug addiction			Herpes			Radiation Treatments
		Anorexia			Dry Mouth			High Blood Pressure			Recent Weight Loss
		Arthritis			Epilepsy or Seizures			High Cholesterol			Renal Disease
		Artificial Heart Valve			Excessive Bleeding			Hives or Rash			Sickle Cell Disease
		Artificial Joint			Excessive Thirst			Hypoglycemia			Sinus Trouble
		Asthma			Fainting/Dizziness			Irregular Heartbeat			Spina Bifida
		Breathing Problem			GERD			Kidney Problems			Stomach Trouble
		Bruise Easily			Glaucoma			Leukemia			Stroke
		Bulimia			Headaches			Liver Disease			Swelling of Limbs/Feet
		Cancer			Heart Attack/Failure			Low Blood Pressure			Thyroid Disease
		Chemotherapy			Heart Murmur			Lung Disease			Tonsillitis
		Chest Pains			Heart Pacemaker			Mitral Valve Prolapse			Tumors or Growths
		Cold Sores			Heart Trouble/Disease			Osteoporosis			Ulcers

Have you ever had any serious illness not listed above? ☐ Y ☐ N Please explain:____

____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the de ice of any changes in my medical status.

Patient Signature ____ Date ______________________

Parent/Guardian Signature ____ Date ______________________