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Steven C. Stacey, DDS
Steven J. Kolenda, DDS

New Patient Registration Form

Patient

Last Name:_____ First Name:_____ M.I._____

Address:_____ Apt./Suite:_____

City:_____ State:_____ ZIP:_____ Marital Status: **M S W D**

Ph #1:_____(Home/Cell/Work) Ph#2:_____ (Home/Cell/Work)

Social Security Number:_____ Birth date:_____/_____/_____ Gender: **M / F**

Employer Name:_____ Address:_____

Primary Physician:_____ Preferred Pharmacy & Address:_____

Last dental visit :_____ Referred by :_____ E-Mail:_____

Emergency Contact Name and Phone Number:_____

Responsible Party

Last Name:_____ First Name:_____ M.I._____

Address:_____ Apt./Suite:_____

City:_____ State:_____ ZIP:_____ Relationship to patient:_____

Social Security Number:_____ Birth date:_____/_____/_____ Gender: **M / F**

Employer Name:_____ Address:_____

Medical History

AIDS ?	YES	NO	Kidney Disease ?	YES	NO
Arthritis ?	YES	NO	Liver Disease ?	YES	NO
Bleeding Problems ?	YES	NO	Mitral Valve Prolapse ?	YES	NO
Blood Transfusion Ever ?	YES	NO	Reaction to Novocain ?	YES	NO
Cancer / Chemotherapy ?	YES	NO	Reaction to Penicillin ?	YES	NO
Diabetes ?	YES	NO	Respiratory Disease ?	YES	NO
Heart Murmur ?	YES	NO	Rheumatism ?	YES	NO
Heart Trouble ?	YES	NO	Rheumatic Fever ?	YES	NO
Hepatitis ?	YES	NO	Smoke ? Tobacco Use ?	YES	NO
High Blood Pressure ?	YES	NO	Stomach Problems ?	YES	NO
Hip or Joint Replacement ?	YES	NO	Thyroid Disease ?	YES	NO
HIV Positive ?	YES	NO	Tumors / Growths ?	YES	NO
Intestinal Problems ?	YES	NO	Venereal Disease ?	YES	NO
Women Only : Are you pregnant ?	YES	NO	Taking a form of birth control ?	YES	NO

LIST ALL ALLERGIES :_____

LIST ALL MEDICATIONS:_____

Do you have any other medical conditions not listed above ?_____