Clayton Valley Dental – New Patient Registration Form

4450 Clayton Road, Concord CA 94521 | Tel. (925.798.2200)

Name: _____ Date of Birth: _____
First Middle Last Social Security #: _____
Email: _____ Cell Phone: _____

Home Address: _____ City _____ State _____ Zip _____
Status (✓): ( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Widower

Employed By: _____City _____ State _____ Work Phone _____

Emergency Contact Name: _____ Emergency Phone: _____

How did you hear about our practice? _____

Insurance Consent

I, the undersigned have insurance coverage with (insurance company):_____ and assign directly to CLAYTON VALLEY DENTAL all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

DATE _____ SIGNATURE _____

Medical Information

1. Are you now or have been under a physicals care during the last five years?_____ Yes/No
2. When (approximately) was your last dental exam? ( ) 0-1 year ( ) 1-2 years ( ) 3+ years
3. What medications are you currently taking? _____
4. Do you have any allergies or sensitivities to medications? _____ Yes/No
5. Do you bleed excessively to cuts or wounds? _____ Yes/No
6. (Circle) Are you subject to fainting, vertigo, nervous disorders, convulsions, or epilepsy? Yes/No
7. Do you have any breathing difficulties or lung disorders? _____ Yes/No
8. Do you currently or recently have had the flu/cold? _____ Yes/No
9. Do you currently have or ever had any of the following:
    - Hearth Problems _____ Yes/No
    - Rheumatic Fever _____ Yes/No
    - Stroke _____ Yes/No
    - Kidney or Liver Disease _____ Yes/No
    - AIDS or HIV positive _____ Yes/No
    - Hepatitis _____ Yes/No
    - High or Low Blood Pressure _____ Yes/No
    - Anemia _____ Yes/No
    - Stomach troubles or ulcers _____ Yes/No
    - Thyroid troubles _____ Yes/No
    - Surgical operations _____ Yes/No
    - Prosthetic joints _____ Yes/No
    - Other medical conditions _____ Yes/No
10. Females: Are you currently (or possibly) pregnant? _____ Yes/No

Doctor Signature _____