Welcome to Missih Dental Care and Periodontics

Thank you for choosing our practice for your dental care needs! We are committed to providing you with the highest level of quality care to ensure a beautiful smile for years to come!

Before your first appointment, please complete and sign the following documents, which are included in your New Patient Information Packet:

- New Patient Registration Form
- Medical History Form

Thanks again for becoming a patient of Missih Dental Care and Periodontics. We look forward to meeting you at your first appointment on _____ located at _____.

Sincerely,

Comlan Missih, DDS

Patient Name: ID #:

PATIENT, INSURANCE, PHARMACY INFORMATION

About You

First Name: _____ Middle initial: _____ Last Name: _____

Street: _____ City: _____ State: _____ Zip: _____

DOB: _____ Age: _____ Sex: ____ Male _____Female _____Unspecified

SS#: _____

Preferred Phone #: _____ Is this a mobile number? Yes_____ No _____

Email address: _____

I would like to receive correspondence via email: ___**Y** ___ **N** I would like to receive correspondence via text: ___**Y** ___ **N**

Emergency Contact: _____ Emergency Phone #:_____

Who may we ***thank*** for referring you? _____

Responsible Party

First Name: _____ Middle initial: _____ Last Name:_____

Street: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: ____ Male _____Female _____Unspecified

Preferred Phone #: _____ Is this a mobile number? Yes_____ No _____

Signature: _____ Date: _____

Primary Dental Insurance

Is subscriber the same as patient? ___ **Y** ____**N** If No, what is the relationship to the patient: _____

Primary Insurance Co. Name: _____Phone #:_____

Subscriber ID/Policy #:_____ Group ID: ____ _____

Insured's Employer Name_____ Effective Date: _____

Insured's Name: _____ DOB: _____ SS #:_____

Secondary Dental Insurance

Is subscriber the same as patient? ___ **Y** ____**N** If No, what is the relationship to the patient: _____

Primary Insurance Co. Name: _____Phone #:_____

Subscriber ID/Policy #:_____ Group ID: ____ _____

Insured's Employer Na_____ Effective Date: _____

Insured's Name: _____ DOB: _____ SS #:_____

Preferred Pharmacy

Name: _____ Phone #: _____

Address: _____

Medical History

NAME:_____ **DOB:**_____ **TODAY'S DATE:**_____

Are you under a physicians care? ☐YES ☐NO IF YES: _____

Have you ever had a major surgery or operation? ☐ NO ☐ Yes If yes: _____

Have you ever had a serious head or neck injury? ☐ NO ☐ Yes If yes: _____

Are you taking any medications, pills, or drugs? ☐ NO ☐ Yes If yes: _____

Do you or have you taken: Phen- Fen, or Redux? ☐NO ☐ Yes If yes : _____

Have you ever taken Fosamax, Boniva, Actonel, or any other medication containing bisphosphonates? Y/N

PLEASE CHECK MARK ALL THAT APPLY:

Aids/HIV Positive ☐
Alzheimer's disease ☐
Anaphylaxis ☐
Anemia ☐
Angina ☐
Arthritis/Gout ☐
Artificial Joint ☐
Asthma ☐
Blood Disease ☐
Blood Transfusion ☐
Breathing Problems ☐
Bruise Easily ☐
Cancer ☐
Chemotherapy ☐
Chest Pains ☐
Cold Sores/Fevers ☐
Heart Disorder ☐
Convulsions ☐
Cortisone Medicine ☐
Diabetes ☐
Drug Addiction ☐
Easily Winded ☐
Emphysema ☐
Epilepsy or Seizures ☐
Excessive Bleeding ☐
Excessive thirst ☐
Fainting Spells/Dizziness ☐
Frequent Cough ☐
Frequent Diarrhea ☐
Frequent Headaches ☐
Genital Herpes ☐
Glaucoma ☐
Hay Fever ☐
Heart Attack/Failure ☐
Heart Murmur ☐
Heart Pacemaker ☐
Heart Trouble/Disease ☐
Hemophilia ☐
Hepatitis A ☐
Hepatitis B or C ☐
Herpes ☐
High Blood Pressure ☐
High Cholesterol ☐
Hives/Rash ☐
Hypoglycemia
Irregular Heartbeat ☐
Kidney Problems ☐
Leukemia ☐
Liver Disease ☐
Low Blood Pressure ☐
Lung Disease ☐
MitroValveProlapse ☐
Osteoporosis ☐
Pain in Jaw joints☐
Parathyroid Disease ☐
Psychiatric care ☐
Radiation☐
Recent Weight Loss ☐
Renal Dialysis ☐
Rheumatic Fever ☐
Rheumatism☐
Scarlet Fever ☐
Shingles☐
Sickle Cell Disease ☐
Sinus Trouble ☐
Spina Bifida ☐
Stomach/Intestinal disease ☐
Stroke ☐
Swelling Of limbs ☐
Thyroid Disease ☐
Tonsillitis ☐
Tuberculosis ☐
Tumors or Growths ☐
Ulcers ☐
Venereal Disease ☐
Yellow Jaundice ☐

Please list any allergies that you have: _____

Woman: Are you breastfeeding? Pregnant? Taking Oral Contraceptives? Circle all that apply.

I have answered all the questions on this form to the best of my knowledge. I understand that providing incorrect information can be dangerous to me or patient's health. It is my responsibility to inform the office of any changes in medical history.

_____ _____
Signature of Patient or Guardian Date