New patient registration

Type in the fields or print and write. A parent or guardian can complete this for a child.

Your contact information

Which office do you visit?

☐ Cornwall ☐ Yorktown Heights ☐ Stony Point ☐ The Bronx ☐ White Plains

Patient's full legal name

Name you like to be called

Date of birth (MM/DD/YYYY)

Best phone number

Street address and apartment

City

State

ZIP code

Email address

Parent or guardian and relationship, if applicable

Emergency contact and relationship

Emergency contact phone

Dental insurance

Complete this section if you have coverage. Bring the front and back of each dental insurance card.

Insurance company and plan

Member or subscriber ID

Subscriber's full name

Subscriber date of birth

Group number

Patient's relationship to subscriber

Additional dental plan, if applicable

Medical history

Your answers help your dentist plan care with you. If an item is unclear, please ask us.

Patient's full name

Date of birth (MM/DD/YYYY)

Primary care clinician or medical office

Office phone

Your health

Mark one answer for each question. Use the space below to explain any "Yes" or "Unsure" answers.

	Yes	No	Unsure
Heart condition, high blood pressure, stroke, or a heart valve replacement?	☐	☐	☐
Bleeding or clotting problem, or do you take a blood thinner?	☐	☐	☐
Diabetes, thyroid disease, or another metabolic condition?	☐	☐	☐
Asthma, sleep apnea, or another breathing or lung condition?	☐	☐	☐
Kidney, liver, immune system, or infectious condition affecting your care?	☐	☐	☐
Cancer therapy, osteoporosis medicines, or head or neck radiation?	☐	☐	☐
Seizures, fainting, or another neurological condition?	☐	☐	☐
Recent surgery, hospitalization, or an artificial joint?	☐	☐	☐
Has a clinician told you to take antibiotics before dental treatment?	☐	☐	☐
Could pregnancy or nursing be relevant to your dental care?	☐	☐	☐

Explain your answers or share other physical or mental health concerns.

Current medicines, doses, and supplements. Include GLP-1 medicines and blood thinners. Write "none" if applicable.

Allergies and reactions, including medicines, latex, or dental materials. Write "none" if applicable.

Dental history & review

Tell us what brings you in and what would make your visit more comfortable.

Patient's full name

Date of birth (MM/DD/YYYY)

Your dental care

What would you like us to help with at this visit?

Any pain, sensitivity, bleeding gums, swelling, or other symptoms? When did they start?

Approximate date of last dental visit

Previous dental practice, if known

Prior dental treatments or difficulties, including reactions to anesthesia, numbing medicine, or sedation.

Is there anything that would help you today, such as language support or changes for your comfort?

Patient or guardian review

I have answered to the best of my knowledge. I will tell my dental team if my health or medicines change.

Printed name of patient or guardian

Relationship to patient

Patient or guardian signature (sign by hand)

Date signed

Dental team review / clinician signature

Review date