NEW PATIENT INFORMATION FORM

Patient's Full Name:______________________________

How do you prefer to be addressed?______________________ **Gender: M F**

Date of Birth:______________ **Age:**________ **SS#:**______________

Single Married Widow Separated Divorced

Mailing Address:____________ **City:**________ **State:**________ **Zip:**________

Home #:______________ **Cell #:**______________ **Preferred #: H C**

Employer:______________ **Occupation:**______________ **City:**________

If Student, name of School / College:______________________________

City:______________ **State:**______________ **Part Time/ Full Time**

Email Address(s):______________________________

Whom may we thank for referring you to our office:______________________

If the person responsible for this patient's account is different from the patient OR if the patient is a minor, the responsible party must fill out the section below. Otherwise, please skip this section.

Full Name of Responsible Party:______________________________

Relationship to Patient:______________________ **Gender: M F**

Date of Birth:______________ **Age:**________ **SS#:**______________

Single Married Widow Separated Divorced

Home #:______________ **Cell #:**______________ **Preferred #: H C**

Employer:______________ **Occupation:**______________ **City:**________

Email Address(s):______________________________

Answers to the following questions are for our records only and will be considered confidential.

Have you or any member of your family been seen by us before? YES NO

If yes, which family member(s)? ______________________________

Date of last physical examination:______________ **Physician's name:**______________

Date of last dental examination:______________ **Date of last dental x-rays:**______________

Previous Dentist's Name: ______________ **City/ State:**______________

PATIENT INSURANCE INFORMATION

Primary Insurance Information

Policy Holders Name:___________________________ **Relationship to Patient:**_______________________

Social Security and/or Member ID #:_______________________________ **Date of Birth:**_____

Name of Employer:_____________________________ **Employer Address:**___________________________

Insurance Company:___________________________ **Phone #:**__________________ **Group #:** _________

Secondary Insurance Information

Policy Holders Name:___________________________ **Relationship to Patient:**_______________________

Social Security and/or Member ID #:____ **Date of Birth:**_____

Name of Employer:_____________________________ **Employer Address:**___________________________

Insurance Company:___________________________ **Phone #:**__________________ **Group #:** _________

MEDICAL AND DENTAL HEALTH HISTORY

Answers to the following questions are for our records only and will be considered confidential.

Please circle any ALLERGIES you currently have:

None	**Amoxicillin**	**Aspirin**	**Barbiturates**	**Codeine**
Erythromycin	**Iodine**	**Latex**	**Local Anesthetic**	**Metals**
Penicillin	**Sulfa**	**Other:**		

Please list any MEDICATIONS you are currently taking:

____________________ ____________________ ____________________
____________________ ____________________ ____________________
____________________ ____________________ ____________________

Place a mark on YES or NO to indicate if you have had any of the following:
(*Antibiotic premedication may be required prior to your appointment)

Heart Failure	Y	N	Angina Pectoris	Y	N	Use of Tobacco Products	Y	N
Heart Disease	Y	N	Hepatitis A (Infectious)	Y	N	Drug Addiction	Y	N
Heart Attack/Problems	Y	N	Hepatitis B (Serum)	Y	N	Alcoholism	Y	N
Heart Surgery	Y	N	Hepatitis C	Y	N	Psychiatric Treatment	Y	N
*Mitral Valve Prolapse	Y	N	HIV positive/ ARC/ AIDS	Y	N	Mood Disorder	Y	N
*Congenital Heart Problems	Y	N	Blood Transfusion	Y	N	Eating Disorder	Y	N
*Heart Murmur	Y	N	Hemophilia	Y	N	Fainting / Dizzy Spells	Y	N
Heart Pacemaker	Y	N	Anemia	Y	N	Epilepsy or Seizures	Y	N
Heart Arrhythmia	Y	N	Bleed/Bruise Easily	Y	N	Tuberculosis (TB)	Y	N
High/Low Blood Pressure	Y	N	Diabetes	Y	N	COPD	Y	N
Stroke	Y	N	Liver Disease	Y	N	Emphysema	Y	N
Cancer - Type:	Y	N	Jaundice	Y	N	Persistent Cough	Y	N
Radiation Therapy	Y	N	Thyroid Disease	Y	N	Asthma	Y	N
Chemotherapy	Y	N	Kidney Trouble	Y	N	Shortness of Breath	Y	N
High Cholesterol	Y	N	Prostate Trouble	Y	N	Shingles	Y	N
*Steroid Treatment	Y	N	Ulcers	Y	N	Hay Fever/Allergies	Y	N
*Artificial Joints	Y	N	GERD/Acid Reflux	Y	N	Hives or Skin Rash	Y	N
*Any Type of Transplant	Y	N	Glaucoma	Y	N	Sinus Trouble	Y	N
*Any Type of Implant	Y	N	Arthritis	Y	N	Herpes	Y	N
*Rheumatic/Scarlet Fever	Y	N	Osteoporosis	Y	N	Cold Sores	Y	N

Please list any OTHER conditions we should be aware of at this time:

____

Have you been advised by your Physician to "Pre-medicate" for dental appointments?	YES	NO
Have you been a patient in the hospital during the past two years?	YES	NO
Have you been under the care of a medical doctor during the past two years?	YES	NO
Have you ever taken Redux or Pondimin (Fen Phen)?	YES	NO

WOMEN:

Are you pregnant now?	**Y N**	**Are you currently breastfeeding?**	**Y N**
If yes, when is your due date?		**Are you taking oral contraceptives?**	**Y N**

How happy are you with your smile? (10 being you love it) **1 2 3 4 5 6 7 8 9 10**

Are you having dental pain or discomfort at this time?	**YES**	**NO**
Do you feel nervous about having dental treatment?	**YES**	**NO**
Have you ever had a bad experience in a dental office?	**YES**	**NO**
Is there anything you would like to speak with the doctor about in private?	**YES**	**NO**
Is there anything you would like to improve about your smile?	**YES**	**NO**
Have you ever had excessive bleeding requiring special treatment?	**YES**	**NO**
Do you have any sores or lumps or growths in or near your mouth?	**YES**	**NO**
Do you habitually clench or grind your teeth during the day or night?	**YES**	**NO**
If yes, do you have a nightguard?	**YES**	**NO**
Do you have problems with bad breath? (Halitosis)	**YES**	**NO**
Do you have any trouble chewing?	**YES**	**NO**
Does food collect between your teeth?	**YES**	**NO**
Have you ever needed to see a periodontist?	**YES**	**NO**
Do you now have bleeding gums or any other gum condition?	**YES**	**NO**

Do you currently have any of the symptoms listed below? Please circle all that apply:

Swelling in Mouth	**Hot Sensitivity**	**Jaw Clicking**
Bad Taste	**Cold Sensitivity**	**Pain in or around your ears**
Bleeding Gums	**Sensitivity to Biting/ Pressure**	**Difficulty opening or closing jaw**
Loose Teeth	**Sensitivity to Sweets**	**History of trauma to your jaw**
		Diagnosed with TMJ/TMD

Is there anything related to your medical or dental history that you have not indicated above? If yes, please explain:

____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/ or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or x-rays, as may be deemed necessary by the doctor.

X______________________________________ **Date:**______________________________

Signature of patient or guardian

I acknowledge I have received a copy of the Practice's Notice of Privacy Practices.

X______________________________________ **Date:**______________________________

Signature of patient or guardian