New Patient Questionnaire

Patient Information

Name:_____ Date:_____
Last First Preferred Name

Birth Date:_____ Gender:_____ Family Status (Single/Married/Child):_____

Social Security #:_____ E-Mail:_____

Phone (Home):_____ (Work):_____ (Cell):_____

Address:_____
Street Apartment #

_____
City State Zip

Emergency Name and Phone Number:_____

Whom may we thank for referring you to our practice? _____

Insurance Information

Primary

Name of Subscriber: _____ Is insured a patient? □ Yes □ No
Last First

Subscriber's Birth Date:_____ ID#:_____ SSN:_____

Subscriber's Employer Name:_____

Patient's Relationship to Subscriber: □ Self □ Spouse □ Child □ Other _____

Insurance Plan Name and Group Name:_____
Address:_____ Phone:_____

Secondary

Name of Subscriber: _____ Is insured a patient? □ Yes □ No
Last First

Subscriber's Birth Date:_____ ID#:_____ SSN:_____

Subscriber's Employer Name:_____

Patient's Relationship to Subscriber: □ Self □ Spouse □ Child □ Other _____

Insurance Plan Name and Group Name:_____
Address:_____ Phone:_____

Medical Health History

Do you have a personal physician? □ Yes □ No
His / Her name:_____

His / Her telephone number:_____

The approximate date of your last doctor's visit:_____

Your current physical health is: □ Good □ Fair □ Poor

Are you currently under the care of any physician? □ Yes □ No
If yes, please explain:_____

Do you smoke or use tobacco in any other form? □ Yes □ No
If yes, how much:_____

Are you currently taking any drugs prescribed by a physician or dentist? □ Yes □ No
If yes, please list:_____

Have you ever taken Phen-Fen? (also known as Redux or Pondimin) □ Yes □ No
If yes, when?_____

Have you ever had any of the following diseases or medical problems?

Y	N	Shingles	Y	N	Cancer/Chemotherapy	Y	N	Severe Headaches
Y	N	Chronic Hepatitis	Y	N	Drug/Alcohol Abuse	Y	N	Tuberculosis (TB)
Y	N	Fever Blisters/Herpes	Y	N	High/Low Blood Pressure	Y	N	Sickle Cell Disease/Traits
Y	N	Heart Attack/Stroke	Y	N	Diabetes	Y	N	Psychiatric problems
Y	N	Anemia	Y	N	Heart Surgery/Pacemaker	Y	N	Hypo/Hyper-thyroidism
Y	N	HIV+/AIDS	Y	N	Hemophilia/Abnormal Bleeding			
Y	N	Kidney Problems	Y	N	Epilepsy/Seizures/Fainting Spells			
Y	N	Sinus Problems	Y	N	Heart Murmur/Rheumatic Fever			

Please list any other serious medical conditions:_____
_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Codeine	Y	N	Dental Anesthetics
Y	N	Penicillin	Y	N	Tetracycline	Y	N	Erythromycin

Y N Latex: If yes; what reaction occurs: _____

Are you allergic to any other drugs? □ Yes □ No
If so, please list:_____

For Women: Are you pregnant or nursing: □ Yes □ No Week #_____

Dental Health Information

Why have you come to the dentist today?

_____

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you under any unusual stress at home or work? ☐ Yes ☐ No

Do you experience stress or anxiety when you visit a dental office? ☐ Yes ☐ No

The approximate date of your last dental visit:_____

Have you ever experienced TMJ problems? (pain or discomfort in your jaw joints) ☐ Yes ☐ No

Do you grind your teeth? ☐ Yes ☐ No

Your assessment of your current dental health is: ☐ Good ☐ Fair ☐ Poor

Rate your smile on a scale of 1-10: _____

Do your gums ever bleed? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No

Do you have Sleep Apnea? ☐ Yes ☐ No

Are you happy with the appearance of your existing fillings? ☐ Yes ☐ No

Consent for Services

I grant my permission to you or your assignee, to telephone me at my work or home to discuss financial issues and other matters related to my relationship with First Impressions Dental Care.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment.

_____ Date:_____ Relationship to Patient:_____

Signature of patient, parent of guardian