New Patient Information

Welcome to our practice.

Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.

Patient Information

Date____

SS/HIC/Patient ID# ______________________________

Last Name ______________________________________

First Name ______________________________________

Address ____

City ____

State ______________________ Zip ________________

E-mail ____

Sex ___ M ___ F   Birthdate:______________Age:________

____ Married   ____ Widowed   ____ Single   ____ Minor

____ Separated   ____ Divorced   ____ Partnered for _______ years

Occupation ______________________________________

Patient Employer/School _________________________

Employer/School Address _________________________

____

Employer/School Phone (____) _____________________

Spouse's Name OR Guardian

____

Birth date _______________________________________

SS# ____

Spouse's Employer _______________________________

Whom may we thank for referring you? ______________

Dental Insurance

Who is responsible for this account? ______________________

Relationship to patient ______________________________

Insurance Company __________________________________

Group # ____

Is patient covered by additional insurance? ____ yes ____ no

Subscriber's Name ___________________________________

Birth date ___________________ SS# ___________________

Relationship to Patient ______________________________

Insurance Co. _______________________________________

Group # ____

ASSIGNMENT AND RELEASE
I certify that I, and/or my dependent(s), have insurance coverage with

___________________________ and assign directly to

Dr. ________________________ all insurance 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 authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may
Disclose such information to the above-named Insurance Company
and their agents for the purpose of obtaining payment for services and
determining insurance benefits or the benefits payable for related services.
This consent will end when my current treatment plan is completed or one
year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

_______________________   _______________________
Date   Relationship to Patient

Phone Numbers

Home (_____) _____________________ Work (_____) _____________________ Ext ________ Cell Phone (_____) ________________

Spouse's Work (_____) ________________________ Best time and place to reach you ______________________________________

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name ____ Relationship ____

Home Phone (_____) _______________________________ Work Phone (_____) _____________________________________

Health History

YOUR NAME ______________________________ **Physician's Name (MEDICAL)**____________________________ Visit____________________

Physician's Address ____ Phone # (_____) _____________________

Have you ever taken any of the group drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names Of phentermine). Pondimin (fenfluramine) and Redux (dexfenfluramine). _____ Yes _____ No

Place a mark on "YES" or "NO" to indicate if you have had any of the following:

AIDS/HIV	____ YES ____ NO	Epilepsy	____ YES ____ NO	Radiation Treatment	____ YES ____ NO
Anemia	____ YES ____ NO	Glaucoma	____ YES ____ NO	Respiratory Disease	____ YES ____ NO
Arthritis/Rheumatism	____ YES ____ NO	Fainting or Dizziness	____ YES ____ NO	Rheumatic Fever	____ YES ____ NO
Artificial Heart Valves	____ YES ____ NO	Headaches	____ YES ____ NO	Scarlet Fever	____ YES ____ NO
Artificial Joints	____ YES ____ NO	Heart Murmur	____ YES ____ NO	Shortness of Breath	____ YES ____ NO
Asthma	____ YES ____ NO	Heart Problems	____ YES ____ NO	Sinus Trouble	____ YES ____ NO
Back Problems	____ YES ____ NO	Hepatitis Type ____	____ YES ____ NO	Skin Rash	____ YES ____ NO
Bleeding Abnormally With extractions or surgery	____ YES ____ NO	Herpes	____ YES ____ NO	Special Diet	____ YES ____ NO
blood Disease	____ YES ____ NO	High Blood Pressure	____ YES ____ NO	Stroke	____ YES ____ NO
Cancer	____ YES ____ NO	Jaundice	____ YES ____ NO	Swollen Feet or Ankles	____ YES ____ NO
Chemical Dependency	____ YES ____ NO	Jaw Pain	____ YES ____ NO	Swollen Neck Glands	____ YES ____ NO
Chemotherapy	____ YES ____ NO	Kidney Disease	____ YES ____ NO	Thyroid Problems	____ YES ____ NO
Circulatory Problems	____ YES ____ NO	Liver Disease	____ YES ____ NO	Tonsillitis	____ YES ____ NO
Congenital Heart Lesions	____ YES ____ NO	Mitral Valve Prolapse	____ YES ____ NO	Tuberculosis	____ YES ____ NO
Cortisone Treatments	____ YES ____ NO	Nervous Problems	____ YES ____ NO	Tumor or growth on head or neck	____ YES ____ NO
Cough, persistent or bloody	____ YES ____ NO	Pacemaker	____ YES ____ NO	Ulcer	____ YES ____ NO
Diabetes	____ YES ____ NO	Psychiatric Care	____ YES ____ NO	Venereal Disease	____ YES ____ NO
Emphysema	____ YES ____ NO				
Cholesterol	_____YES _____NO			Weight loss unexplained	____ YES ____ NO

ARE THERE ANY OTHER MEDICAL ISSUES/MEDICATIONS YOU TAKE THAT ARE NOT ABOVE? YES OR NO IF YES PLS EXPLAIN: _____

____

Do you wear contact lenses? ____ YES ____ NO

Women:

Are you pregnant? ____ YES ____ NO Due date ____________________ Are you nursing? ____ YES ____ NO

Are you taking birth control pills? ____ YES ____ NO

Medications

List any medications you are currently taking the correlating diagnosis:

____

____

ARE YOU TAKING? FOSOMAX____ BONIVA____ DIDRONEL____ AREDIA____ ACTONEL____ SKELID____ NONE____

Pharmacy Name ____ Phone # (_____) ______________________________________

Allergies to Foods or Medications

____ Aspirin ____ Barbiturates (sleeping pills) ____ Codeine ____ Iodine ____ Latex ____ Local Anesthetic ____ Penicillin ____ Sulfa

Other allergies to foods or medications ____

Vital Signs

Blood Pressure _________ Pulse ________ Date _________

Blood Pressure _________ Pulse ________ Date _________

Blood Pressure _________ Pulse ________ Date _________

Blood Pressure _________ Pulse ________ Date _________

Blood Pressure _________ Pulse ________ Date _________

Premedication: Do you need to premedicate?

Medication _____________ Date _________ Initials ________

Medication _____________ Date _________ Initials ________

Medication _____________ Date _________ Initials ________

Medication _____________ Date _________ Initials ________

Medication _____________ Date _________ Initials ________

Patient's/Guardian Signature ____________________________________ *Date*______________

Doctor's Signature ____________________________________ Date __________________________

Dental History

What brings you here today? ____

Former Dentist______________________________ Phone # (____) ____________________

City / State ____

Date of last dental visit ____________________ Date of last dental X-rays ____________________

Question			Question		
Do you have bad breath?	____ YES	____ NO	Do you have bleeding gums?	____ YES	____ NO
Do you have blisters on lips or mouth?	____ YES	____ NO	Do you have a burning sensation on tongue?	____ YES	____ NO
Do you chew on one side of mouth?	____ YES	____ NO	Do you smoke cigarette, pipe, cigar?	____ YES	____ NO
Do you have clicking or popping jaw?	____ YES	____ NO	Do you have dry mouth?	____ YES	____ NO
Do you bite your fingernails?	____ YES	____ NO	Do you have food collection between teeth?	____ YES	____ NO
Do you grind your teeth?	____ YES	____ NO	Are your gums swollen or tender?	____ YES	____ NO
Do you bite your lips or cheeks?	____ YES	____ NO	Do you have loose or broken teeth?	____ YES	____ NO
Do you have sensitivity to cold?	____ YES	____ NO	Do you have sensitivity to hot?	____ YES	____ NO
Do you have sensitivity to sweets?	____ YES	____ NO	Do you have pain when biting/chewing?	____ YES	____ NO
Do you have sores or growths in our mouth?	____ YES	____ NO	Do you have TMJ pain?	____ YES	____ NO

How often do you floss? ____________________ How often do you brush? ____________________

What has your previous dental experience been like?

____

What can we do to make your visit exceptional today? Neck rest? I-pod player with BOSE headsets? Blanket?

____

Smile Evaluation

We would like to help you obtain the smile you've always wanted. Please take a few minutes to complete this short questionnaire. While using a mirror or looking at a photograph, please observe your teeth carefully.

1. Do you have any concerns about bad breath odor?
   ____
2. Are you pleased with the appearance of your teeth when you smile?
   ____
3. Are you pleased with the color of your teeth?
   ____
4. Are you pleased with the shape of your teeth?
   ____
5. Are there spaces between your teeth that you do not like?
   ____
6. Are your teeth chipped?___ protruding?___ hidden?___ crowded?___
7. Do you like the way your teeth fit together when you bite?
   ____
8. Are there old fillings or dental treatment that you aren't happy with?
   ____
9. If you could change anything about the appearance of your smile, what would that be?
   ____
10. Is there anything about the shape or alignment of your jaws that you are not happy with?
    ____

Thank you again for taking the time to fill out this form. We appreciate you helping us become an extraordinary practice and we hope to make your experience here a pleasant one.