New Patient Form

PATIENT INFORMATION

Today's Date: _____
Name:_____
Date of Birth:_____ Age: _____
Male/Female
SS#: _____
Home Address: _____
_____
_____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email: _____
Person Responsible for Account:_____
_____
Spouse Info: _____
Spouse Phone: _____

Emergency Contact: _____
Relationship: _____
Phone: _____

How did you hear about our office?
_____
_____

DENTAL INFORMATION

Primary Dental Insurance

Insurance Company: _____
Phone: _____
Group #: _____

Insured's Name: _____
Relation: _____
Insured's SS#: _____
Insured's Birthday: _____
Insured's Employer: _____

Secondary Dental Insurance (if any)

Insurance Company: _____
Phone: _____
Group #: _____

Insured's Name: _____
Relation: _____
Insured's SS#: _____
Insured's Birthday: _____
Insured's Employer: _____

Previous Dentist: _____

When was your last dental visit: _____

MEDICAL HISTORY

Your current physical health is Good/Fair/Poor
Date of last medical exam: _____
Do you use or smoke Tobacco in any form? Yes No

Are you taking any prescription/ over-the-counter or herbal supplement drugs? Yes No
Please list each one: _____
Have you ever taken Phen-Fen? Yes No
(also known as Redux or Pondimin) if yes when? _____

FOR WOMEN:
Are you taking birth control pills? Yes No
Are you pregnant? Yes No Expected Deliver Date: _____
Are you nursing? Yes No
Is there a possibility of pregnancy? Yes No

NOTE: Antibiotics (such as penicillin) may alter the effect of birth control pills. Consult your doctor for assistance regarding additional methods of birth control.

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

Y N Abnormal Bleeding
Y N Herpes/fever blisters
Y N Alcohol/Drug Use
Y N High Blood Pressure
Y N Anemia
Y N HIV+/Aids
Y N Arthritis
Y N Hospitalized for any reason
Y N Artificial Bones/Joints/valves
Y N Kidney Problems
Y N Asthma
Y N Liver Disease
Y N Blood Transfusion
Y N Low Blood Pressure
Y N Cancer/Chemotherapy
Y N Lupus
Y N Colitis
Y N Mitral valve prolapse
Y N Congenital Heart defect
Y N Pacemaker
Y N Diabetes
Y N Psychiatric Problems
Y N Difficulty Breathing
Y N Radiation Treatment
Y N Emphysema
Y N Rheumatic/Scarlet fever
Y N Epilepsy
Y N Seizures
Y N Fainting Spells
Y N Shingles
Y N Frequent Headaches
Y N Sickle Cell Disease
Y N Glaucoma
Y N Sinus Problems
Y N Hay Fever
Y N Stroke
Y N Heart Attack
Y N Thyroid Problems
Y N Heart Murmur
Y N Tuberculosis (TB)
Y N Heart Surgery
Y N Ulcers
Y N Hemophilia
Y N Venereal Disease
Y N Hepatitis

Please list any medical conditions you have ever had: _____

ALLERGIC REACTIONS:

Are you allergic to any of the following:
Y N Aspirin
Y N Erythromycin
Y N Penicillin
Y N Codeine
Y N Jewelry/Metals
Y N Tetracycline
Y N Sulfa
Y N Latex
Y N Dental Anesthetics

Please list any other drugs/materials you are allergic to: _____
_____

DENTAL HISTORY

Reason for today's visit: _____
You current dental health is: Good/Fair/Poor?
Are you currently in pain? Y N

Has your doctor told you that you require antibiotics before dental treatment? Y N

Have you had problems with previous dental work? Y N
Do you experience pain/discomfort in your jaw (TMJ or TMD)? Y N
Do your gums ever bleed? Y N

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature: _____ **Date:** _____