

NEW PATIENT FORM

Our office is dedicated to the concept that all people should have the right to retain their natural teeth for a lifetime. Preventative measures, high quality care and good cooperation combined with timely treatment make it possible for most people to retain their natural teeth with optimum comfort, function and appearance. Our staff is dedicated to this concept and with your cooperation we will do everything we can to help you reach your goals for dental health.

DATE: _____

PATIENT NAME: _____ I PREFER TO BE CALLED _____

ADDRESS _____ HOME PHONE _____

CITY/STATE/ZIP _____ WORK PHONE _____

BIRTH DATE: _____ CELL PHONE _____

SEX: M ___ F ___ MARITAL STATUS S ___ M ___ D ___ W ___

SS# _____ EMAIL _____

EMPLOYER _____ OCCUPATION _____

SPOUSE'S NAME _____ SPOUSE'S EMPLOYER _____

EMERGENCY CONTACT _____ PHONE # _____

We will gladly assist you in filing the claims for your primary insurance if provided with the necessary information and a copy of the insurance card.

NAME OF PERSON WHO HAS POLICY _____

SS# OF POLICY HOLDER _____ BIRTH DATE _____

NAME OF INSURANCE CO. _____ INS GROUP # _____

WHOM MAY WE THANK FOR THIS REFERRAL?

PHONE BOOK _____ NEWSPAPER _____ RADIO _____ INTERNET _____

OTHER FAMILY MEMBERS SEEN IN OUR
OFFICE _____

I understand that payment is expected on the day of each service. I realize I am also responsible for any remaining charges that my insurance company chooses not pay.

SIGNATURE _____

DENTAL HEALTH QUESTIONS

UPDATED 3/08

When was your last dental visit? _____

Who was your previous dentist? _____

Do you have sensitive teeth? _____ If so, what to? _____

Do your gums bleed when you floss? _____

What would you like to change about the appearance of your smile? _____

Do you have any fears about visiting the dentist (pain, cost, previous bad experience, lack of

time)? _____

On a scale of 1-10, how would you rate your dental health? (1 being poor-10 being excellent)?

Circle one: 1 2 3 4 5 6 7 8 9 10

MEDICAL HEALTH QUESTIONS

Physician _____ Date of last visit _____

Medications you are currently taking: _____

Allergies to Medications _____

Any Recent Illness? _____

Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Do you have a history of the following?

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> HIV positive | <input type="checkbox"/> |
| Respiratory disease | | | |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Fainting | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Shortness of |
| Breath | | | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Swelling Feet/Ankle |
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Heart problem | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Cancer | Describe _____ | <input type="checkbox"/> Phen-fen or Diet pills | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Chemical Dependent | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Radiation Treatment | |
| <input type="checkbox"/> Venereal Disease | | | |

OTHER _____
