



New Patient Information

Patient Information

Date _____

Patient Name _____

Address _____

City _____ State _____ Zip _____

Email _____

Sex M F Age _____ Birthdate _____

SS# _____

Circle one: Married Widowed Single Minor
Separated Divorced Partnered

Patient employer/school _____

Spouses/Partner's name _____

Spouses/Partner's birth date _____

Employer _____

Whom may we thank for referring you? _____

Phone Numbers

Home _____ Work _____

Cell _____ Best Time to reach you _____

IN CASE OF EMERGENCY CONTACT _____

Relationship _____

Home# _____ Work# _____

Dental History

Reason for today's visit _____

Former Dentist _____ City _____ State _____

Date of last dental visit _____

Date of last x-rays _____

Bad Breath Yes / No Bleeding Gums Yes / No

Chew on one Side of Mouth Yes / No Cigarette, pipe or cigar smoker Yes / No

Dry Mouth Yes / No Gums Swollen or Tender Yes / No

Mouth Breathing Yes / No Orthodontic Treatment Yes / No

Sensitivity to Hot Yes / No Sensitivity to Sweets Yes / No

Fingernail Biting Yes / No Food Collection between teeth Yes / No

Sores/Growths in Mouth Yes / No Daytime Sleepiness Yes / No

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by another insurance? YES NO

Subscriber's name _____

Birthdate _____ 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 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 doctor may use my health care information and may such information to the above insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of 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, Guardian or Personal Representative

Print Name _____ Date _____

Relationship to Patient _____

Burning Sensation On Tongue Yes / No Blisters on Lips or Mouth Yes / No

Chew Tobacco Yes / No Clicking or Popping Jaw Yes / No

Jaw Pain or Tiredness Yes / No Loose Teeth or Broken Fillings Yes / No

Pain Around Ear Yes / No Sensitivity to Cold Yes / No

Frequent Headaches Yes / No Sensitivity when Biting Yes / No

Grinding Teeth Yes / No Lip or Cheek Biting Yes / No

Do Your or Your Spouse/Sleeping Partner Snore Yes / No How Often Do You Floss? _____

How Often Do You Brush? _____

Medical History

Physician's Name _____ Date of last visit _____

Are you currently under medical treatment? Yes / No

Have you ever had any serious illness or operations? Yes / No

Are you taking any medication? Yes / No

Please list any medication you are taking: _____

Have there been any changes in your health since your last appointment?

Please Describe: _____

(Woman Only) Are you:

Pregnant? Yes / No

Nursing? Yes / No

Taking birth control pills? Yes / No

Have you ever had any allergic reactions to the following?

Local Anesthetic (Novocaine) Yes / No

Penicillin or other Antibiotics Yes / No

Aspirin Yes / No

Latex Yes / No

Barbiturates (Sleeping Pills) Yes / No

Please circle Yes or No to all that apply (Antibiotic premeditation may be required before dental appointments. Documentation from physician required.)

AIDS/HIV	Yes/No	Epilepsy	Yes/No	Pacemaker	Yes/No
Anemia	Yes/No	Fainting/Dizziness	Yes/No	Respiratory Disease	Yes/No
Arthritis	Yes/No	Glaucoma	Yes/No	Scarlet Fever	Yes/No
Artificial Joints	Yes/No	Headaches	Yes/No	Shortness of Breath	Yes/No
Asthma	Yes/No	Heart Murmur	Yes/No	Sinus Trouble	Yes/No
Back Problems	Yes/No	Heart Problems	Yes/No	Skin Rash	Yes/No
Blood Disease	Yes/No	Hepatitis Type ____	Yes/No	Special Diet	Yes/No
Cancer	Yes/No	Herpes	Yes/No	Stroke	Yes/No
Chemical Dependency	Yes/No	High Blood Pressure	Yes/No	Swollen Feet/Ankles	Yes/No
Chemotherapy	Yes/No	Jaundice	Yes/No	Swollen Neck Glands	Yes/No
Circulatory Problems	Yes/No	Jaw Pain	Yes/No	Thyroid Problems	Yes/No
Congenital Heart Lesions	Yes/No	Kidney Disease	Yes/No	Tonsillitis	Yes/No
Cortisone Treatments	Yes/No	Liver Disease	Yes/No	Tuberculosis	Yes/No
Cough (Persistent)	Yes/No	Low Blood Pressure	Yes/No	Tumor on head/neck	Yes/No
Diabetes	Yes/No	Mitral Valve Prolapse	Yes/No	Ulcer	Yes/No
Emphysema	Yes/No	Nervous Problems	Yes/No	Venereal Disease	Yes/No

Is there family history of any of the above? _____

Signature or Responsible Party

Date