New Patient Form

Patient Info

The patient is a/an:	◯ Adult ◯ Child ◯ Adult under Guardianship
Patient's First Name	
Patient's Middle Name	
Patient's Last Name	
Preferred Name	
Date of Birth	
Gender	◯ Male ◯ Female ◯ Other ◯ Prefer Not To Say
Title	◯ Dr. ◯ Mr. ◯ Mrs. ◯ Ms.
Martial Status	◯ Single ◯ Married ◯ Divorce ◯ Seperate ◯ Widow ◯ Prefer Not To Say
Street Address	
Apt/Suite/Unit #	
City	
State	
Zip Code	
Home Phone	
Cell Phone	
Email	
Occupation	
Employer	
Work Phone	
Preferred method of contact?	◯ Phone Call ◯ Text ◯ Email
Whom may we thank for referring you ?	

Guardian's Info

Full Name	
Relationship to the Patient	
Phone Number	

Email	

Emergency Contact

In case of medical emergencies and we need to inform someone about your condition, please give us the contact information that is is able to help you.

Guardian, please put information that is different from yours. Someone who is able to assist when you are not available, or someone who can get a hold of you in case of an emergency.

Full Name	
Relationship to the Patient	
Phone Number	
Email	

Insurance

Do you have Dental Insurance?	◯ Yes ◯ No
Primary Insurance Name	
Primary Insurance Number/ID	
Primary Insurance Plan Number	
Secondary Insurance Name	
Secondary Insurance Number/ID	
Secondary Insurance Plan Number	

Dental History

Please check YES/NO to each question. If you're unsure how to answer, please consult our staff!

Is there a dental problem you would like treated immediately?	◯ Yes ◯ No
Do you have dental anxiety? If yes, please explain below?	
Reason for today's visit?	
Date of your last dental visit?	
Last dental cleaning?	
Last dental x-ray?	
Are you having regular dental visits?	◯ Yes ◯ No
Have you ever had any of the following?	☐ Periodontal Treatment (treatment of gums) ☐ Your bite adjusted or teeth ground ☐ Orthodontic Treatment (to straighten or realign teeth) ☐ Oral Surgery (surgery in or about the mouth/jaw joint, or implant surgery in one or both of your jaw joints) ☐ A bite plate or any other appliance
How often do you brush and floss your teeth?	
Do you use dental floss, proxabrush, stiudents, or any other	◯ Yes ◯ No

interpoximal tools?	
Do your gums bleed when brushing or eating, or do you suffer from pain or swelling of your gums?	
Have you ever experienced any of the following? Check all that apply:	☐ Popping/clicking in your jaw joints ☐ Pain when teeth are clenched ☐ Pain in your jaw joints, around your ear, or side of your face ☐ Pain or difficulty when chewing ☐ Difficulty in opening or closing ☐ Bad Breath ☐ Blisters on lips or mouth ☐ Burning sensation on tongue ☐ Chew on one side of mouth ☐ Dry mouth ☐ Food collection between teeth ☐ Loose teeth or broken fillings ☐ Mouth Pain, Brushing ☐ Sensitivity to Cold, Hot, Sweets or biting ☐ Sores or growths in your mouth
Do you have any of the following habits?	☐ Clenching or grinding your teeth while awake or asleep ☐ Placing foreign objects in your mouth (pencils, fingernails, pens) ☐ Biting your cheeks or lips ☐ Mouth breathing while awake or asleep ☐ Cigarette, pipe, or cigar smoking

Medical History

Physician's name and Phone number:	
Date of last visit:	
Have you ever used a bisphosphonate medication? Common brand names are Fosamaz, Actonel, Altevia, Didronel, Boniva.	◯ Yes ◯ No
Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).	◯ Yes ◯ No
Are you being treated for any medical condition at present or within the past years? If yes, please explain.	
Has there been any changes in your general health in the past year?	
Have you ever been advised against taking any specific type of medication?	
Do you bleed excessively from a cut/injury, bruise easily, or have any blood disorders? If yes, please explain.	
Have you ever fainted during dental or medical treatment?	◯ Yes ◯ No
Do you have any artificial joints (e.g. hip, knee)?	◯ Yes ◯ No
Indicate which of the following you presently have, or ever had: (Please check all that apply)	☐ Asthma ☐ Glandular Disorders ☐ Diabetes ☐ Jaundice ☐ Lung Disease ☐ Ulcers ☐ Epilepsy or Seizures ☐ Bronchitis ☐ Organ Transplant/Medical Implant ☐ Kidney Disease ☐ Liver Disease ☐ Tuberculosis ☐ Hepatitis ☐ Emphysema ☐ Stomach/Intestinal Problems ☐ Thyroid Disease ☐ AIDS/HIV ☐ Anemia ☐ Arthritis, Rheumatism ☐ Artificial Heart Valves ☐ Back Problems ☐ Bleeding abnormally, with extractions or surgery ☐ Cancer ☐ Chemical Dependency ☐ Chemotherapy/Radiation Treatment ☐ Circulatory Problems ☐ Congenital Heart lesions ☐ Cortisone Treatments ☐ Cough, Persistent or bloody ☐ Fainting or dizziness ☐ Glaucoma ☐ Headaches ☐ Heart Murmur ☐ Heart Problems ☐ Herpes ☐ High blood pressure ☐ Jaw pain ☐ Low blood pressure ☐ Mitral Valve

	prolapse ☐ Nervous Problems ☐ Pacemaker ☐ Psychiatric care ☐ Respiratory Disease ☐ Rheumatic fever ☐ Scarlet fever ☐ Shortness of breath ☐ Sinus trouble ☐ Skin rash ☐ Stroke ☐ Swollen Feet, Ankles, or Neck glands ☐ Tonsillitis ☐ Tumor or growth on head or neck ☐ Venereal Disease
Is there anything else about your health we should be made aware of; or do you wish to speak to the doctor privately about any problem or medical condition?	

Medications

List any medications you are currently taking and the correlating diagnosis:	
Allergies	☐ Allergies or Hives ☐ Anesthetic ☐ Aspirin ☐ Codeine ☐ Ibuprofen ☐ Iodine ☐ Latex ☐ Penicillin ☐ Sulfa

Women Only

Taking birth control pills?	◯ Yes ◯ No
Are you pregnant?	◯ Yes ◯ No
Are you breast feeding?	◯ Yes ◯ No