

New Patient



Patient Information *Let's get to know each other...*

MRS MR MS MISS DR THIS PATIENT IS A ADULT CHILD

PATIENT NAME		PREFERRED NAME		ZIP
<input type="text"/>		<input type="text"/>		<input type="text"/>
HOME ADDRESS	CITY	STATE	SSN #	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
HOME PHONE	OTHER PHONE	EMAIL		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
BIRTHDAY	SEX	EMPLOYER / SCHOOL	OCCUPATION	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	

Would you be available on short notice for future appointments or changes? YES NO

We would like to be able to send email and text communications to you, which would include appointment confirmations, newsletter, upcoming events, and important notifications. Check this box if you would like to receive these communications from us—you'll be able to unsubscribe at anytime. OPT-IN

Physician and Emergency

FAMILY PHYSICIAN	PHONE	
<input type="text"/>	<input type="text"/>	
EMERGENCY CONTACT	RELATIONSHIP	PHONE
<input type="text"/>	<input type="text"/>	<input type="text"/>

Person Responsible

Please complete the information if different from above

SELF SPOUSE PARENT LEGAL GUARDIAN OTHER

PERSON RESPONSIBLE FOR THIS ACCOUNT	RELATION TO PATIENT		
<input type="text"/>	<input type="text"/>		
HOME ADDRESS	CITY	STATE	ZIP
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Insurance Info

If you have a dental plan, please complete the following

SUBSCRIBER	RELATION	INSURANCE COMPANY
<input type="text"/>	<input type="text"/>	<input type="text"/>
POLICY PLAN #	DIVISION/SECT #	SUBSCRIBER ID
<input type="text"/>	<input type="text"/>	<input type="text"/>
SUBSCRIBER (SECONDARY)	RELATION	INSURANCE COMPANY
<input type="text"/>	<input type="text"/>	<input type="text"/>
POLICY PLAN #	DIVISION/SECT #	SUBSCRIBER ID
<input type="text"/>	<input type="text"/>	<input type="text"/>

Our Policies

Our payment, cancellation, and other policies

Unless an emergency arises, we will always try to be prompt. We appreciate all of our patients doing the same—however if you need to reschedule an appointment please give us a **48 HOURS** notice to avoid incurring a charge of **\$150** for a missed appointment.

• Cash, check or credit card at the time of treatment. • If using dental insurance, we will help you with filing claims. • If payment is not made within 30 days of service, an interest charge of 1.5%/month or 18%/year on unpaid balances will incur. • After 90 days, unpaid bills will be turned over to our collection agency for which they will charge a reasonable fee, in addition to an interest of 18%/year.

I have been shown a copy of HIPAA
 YES NO

Signature _____
 PATIENT PARENT GUARDIAN

Date _____

**Dental
History**

1. Do you have a dental problem that you would like to have taken care of as soon as possible? YES NO
2. Have you been visiting the dentist regularly prior to visiting our practice? YES NO
3. Date of last dental visit: ___/___/___.
Date of last cleaning: ___/___/___.
4. When did you last have dental x-rays taken? ___/___/___
5. How often do you brush your teeth? _____
6. How often do you floss your teeth? _____
7. Do your gums bleed when you brush or floss your teeth? YES NO
8. Do you feel any pain in your teeth? YES NO
9. Do you think you have bad breath at times? YES NO
10. Have you ever had an injury to your mouth or jaw? YES NO
11. Do you have any pain in your jaw joints? YES NO
12. Do you suffer from migraine headaches? YES NO
13. Have you had your wisdom teeth extracted? YES NO
14. Have you ever received a dental implant? If so please provide the approximate date(s): ___/___/___
15. Do you grind or clench your teeth during the daytime or at night? YES NO
16. Do you smoke or use any other form of tobacco? YES NO
17. Have you noticed any lumps, growths, or sore spots in your mouth? YES NO
18. Have you ever had periodontal treatment or been referred to a periodontist? YES NO
19. Have you had any previous problems with dental treatment? YES NO
20. Are you happy with the appearance of your teeth? YES NO
21. Are you nervous about coming to the dentist or undergoing dental treatment? YES NO
22. Do you experience frequent dry mouth? YES NO
23. Do you snore? YES NO
24. Do you use a C-PAP machine? YES NO



Medical History

1. Are you in good health? YES NO
2. Have you had any significant changes to your health or weight in the last year? YES NO
3. Are you currently being treated for any medical condition or have you been in the last year? YES NO
4. Do you have a primary care physician? If so then who _____
5. When was your last physical examination by your primary care physician? _____
6. Have you ever been hospitalized for an illness or any other medical condition? YES NO
7. Please list any medications, non-prescription drugs, or herbal supplements that you currently take:

8. Do you have any allergies to medication, latex/rubber, or anything else? If yes please list:

9. Do you experience any difficulty walking or exercising or experience shortness of breath? YES NO
10. Please list and provide the date of any surgery that you have ever had: _____
11. Have you ever been instructed to take an antibiotic premedication prior to dental treatment or a dental cleaning? YES NO
12. Do you have any artificial joints or heart valves? YES NO
13. Do you have HIV, leukemia, or any other condition that could impact your immune system? YES NO
If HIV+ are you currently in care? YES NO
14. Do you experience prolonged bleeding, have a bleeding disorder, or are taking blood thinners? YES NO
15. Please check any of the following conditions that you have ever had or currently have:

<input type="radio"/> Chest pain, angina	<input type="radio"/> Osteoporosis medication	<input type="radio"/> Cancer
<input type="radio"/> Heart attack	<input type="radio"/> Psychiatric disorder / treatment	<input type="radio"/> Steroid therapy
<input type="radio"/> Stroke	<input type="radio"/> Circulatory problems	<input type="radio"/> Diabetes
<input type="radio"/> Rheumatic fever	<input type="radio"/> Blood transfusions	<input type="radio"/> Stomach ulcers
<input type="radio"/> Mitral valve prolapse	<input type="radio"/> Eating disorder	<input type="radio"/> High blood pressure
<input type="radio"/> Heart problems, murmur	<input type="radio"/> Fainting / Dizzy spells	<input type="radio"/> Arthritis / Rheumatism
<input type="radio"/> Asthma or Emphysema	<input type="radio"/> High / Low blood pressure	<input type="radio"/> Seizures / Epilepsy
<input type="radio"/> Pacemaker	<input type="radio"/> Hyper / Hypoglycemia	<input type="radio"/> Kidney disease
<input type="radio"/> Lung disease	<input type="radio"/> Mental or Nervous disorder	<input type="radio"/> Thyroid disease
<input type="radio"/> Tuberculosis	<input type="radio"/> Other communicable disease	<input type="radio"/> Drug / Alcohol dependency
	/ Transmissible infection	
16. Please list any other condition that you have had not listed above: _____
17. Are you currently pregnant or breastfeeding? If pregnant, expected delivery date: ___/___/___
18. Have you developed a fever or chills in the last 24 hours? YES NO
19. Have you noticed a new rash, lesion, or outbreak anywhere on your skin? YES NO
20. Are your immunizations up to date? YES NO
21. Have you ever taken any oral or IV bisphosphonates (i.e. Fosomax, Reclast, Zoledronic acid, etc)? YES NO
22. Which medications do you normally take to manage pain? (i.e. Tylenol, advil, etc): _____
23. Have you ever been treated with radiation therapy to your head, neck, or jaw? YES NO
24. Have you ever undergone chemotherapy? YES NO
25. Is there any additional information pertaining to your overall health or dental history that has not been addressed above? YES NO