

New Patient Information

PATIENT'S NAME Last _____ First _____ Middle _____
SEX: M F BIRTHDATE _____ AGE _____ SOCIAL SECURITY # _____
If patient is a Minor, give Parent's or Guardian's Name _____
TODAY'S DATE _____ Who Referred you to our office? _____
Reason for your visit today? _____
Patients Home Mailing Address _____
Place of employment? _____

RESPONSIBLE PARTY INFORMATION (Patient or Parent if Patient is under the age of 18)

NAME Last _____ First _____ Middle _____ Marital Status _____
RESIDENCE Street _____ City _____ State _____ Zip _____
MAILING ADDRESS Street _____ City _____ State _____ Zip _____
PREVIOUS ADDRESS (if less than 3 years)
Street _____ City _____ State _____ Zip _____ How Long? _____
SOCIAL SECURITY # _____ BIRTHDATE _____
RELATION TO PATIENT _____ EMPLOYER _____
OCCUPATION _____ No. YEARS EMPLOYED _____

RESPONSIBLE PARTY'S SPOUSE

NAME _____
EMPLOYER _____
No. YEARS EMPLOYED _____
OCCUPATION _____
SOC. SEC. # _____
WORK PHONE _____
BIRTHDATE _____

EMERGENCY INFORMATION

REALATIVE NOT LIVING WITH YOU

NAME _____
ADDRESS _____
CITY, STATE _____
PHONE _____
WORK PHONE _____
RELATION TO PATIENT _____

DENTAL INSURANCE INFORMATION

PRIMARY

Insured's Name _____
Insurance Co. _____
Insured's Employer _____
Insured's Soc. Sec. # _____
Group # _____

DENTAL INSURANCE INFORMATION

SECONDARY

Insured's Name _____
Insurance Co. _____
Insured's Employer _____
Insured's Soc. Sec. # _____
Group # _____

HOME PHONE # _____

WORK PHONE # _____

CELL PHONE # _____

EMAIL ADDRESS _____

PHARMACY _____

New Patient Information Continue

DENTAL HISTORY		
WHEN WAS YOUR LAST EXAM? _____		
WHEN WAS YOUR LAST X-RAY? _____		
ARE YOU HAVING PROBLEMS NOW? _____	Y	N
WHAT? _____		
Is your present dental health POOR? _____	Y	N
Do you wear DENTURES (partials)? _____	Y	N
Are you UNHAPPY with your dentures? _____	Y	N
Are you APPREHENSIVE about treatment? _____	Y	N
Have you had any Periodontal treatment? _____	Y	N
Do your gums bleed, or feel irritated? _____	Y	N
Are your teeth sensitive? _____	Y	N
TO WHAT? _____		
Are you unhappy with how your teeth look? _____	Y	N
Do you grind or clench your teeth? _____	Y	N
Complaint of headaches, earaches, or neckpains? _____	Y	N
Have you worn braces on your teeth? _____	Y	N
Does the color of your teeth bother you? _____	Y	N
Would you like your smile to look better? _____	Y	N
Do you REGULARLY use dental floss? _____	Y	N
Name of Previous Dentist? _____		
City, State: _____		

MEDICAL HISTORY		
Do you currently have health problems? _____	Y	N
Are you under physicians care now? _____	Y	N
FOR WHAT? _____		
Are you PREGNANT? _____	Y	N
Do you Smoke? _____	Y	N
Do you have any ALLERGIES? _____	Y	N
WHAT? _____		

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

Heart Disease or Attack	AIDS/HIV	Bruise Easily
Angina Pectoris	Hepatitis A	Emphysema or Asthma
High Blood Pressure	Hepatitis B	Tuberculosis (TB)
Heart Murmur	Liver Disease	Hay Fever
Rheumatic Fever	Blood Transfusion	Sinus Trouble
Congenital Heart Lesions	Drug Addiction	Allergies or Hives
Mitral Valve Prolapse	Hemophilia (bleeding)	Diabetes
Artificial Joints	Fever Blisters	Thyroid Disease
Anemia	Epilepsy or Seizures	Radiation Treatment
Stroke	Nervousness	Arthritis
Kidney Trouble	Psychiatric Treatment	Cortisone Medicine
Ulcers	Glaucoma	Pain in Jaw Joints
	Chemotherapy	Alcoholism
	Veneral Disease	Cosmetic Surgery

IS THERE ANY OTHER MEDICAL OR DENTAL INFORMATION THAT YOU FEEL WE SHOULD KNOW?

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS? (Please circle any that apply)

*Latex	*Aspirin	*Local Anesthetic	*Erythromycin
*Sulfa	*Nitrous Oxide	*Codeine	*Penicillin

PLEASE LIST MEDICATIONS YOU ARE CURRENTLY TAKING AND DOSAGE:
