

# New Patient Information Form

Please complete the information below, print the pages and bring with you to your first appointment.

## PATIENT INFORMATION

Date:  
Patient:  
Address:  
City:  
State: Zip:  
Sex: Male Female  
Age: Birthdate:  
Single Married Widowed  
Separated Divorced  
Patient SS#  
Occupation:  
Employer:  
Employer Address:  
Employer Phone:  
Spouse's Name:  
Spouse's Birthdate:  
Spouse's SS#:  
Occupation  
Spouses Employer:  
Whom may we thank for referring you?

## DENTAL INSURANCE

Who is responsible for this account?  
Relationship to patient?  
Insurance Company?  
Group Number:  
Is patient covered by additional insurance? Yes No  
Subscriber's Name:  
Birthdate: SS#  
Relationship to patient?  
Insurance Company?  
Group Number:

## ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with and assign directly to 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party  
Signature:  
Relationship: Date:

## PHONE NUMBERS

Home: Work: Ext. Spouse's Work:  
Best time and place to reach you?

IN CASE OF EMERGENCY, CONTACT (Specify Someone who does not live in your household.)

Name:

Relationship:

Home Phone:

Work Phone:

DENTAL HISTORY

Reasons for today's visit? Foreign objects Yes

Grinding teeth Yes

Gums swollen or tender Yes

Former Dentist: Jaw pain or tiredness Yes

City/State: Lip or cheek biting Yes

Date of last dental visit: Loose teeth or broken fillings Yes

Click "Yes" to indicate if you have had any of the following. Leave blank if you have not. Mouth breathing Yes

Mouth pain, brushing Yes

Bad Breath Yes Orthodontic treatment Yes

Bleeding Gums Yes Pain around ear Yes

Blisters on lips or mouth Yes Periodontal treatment Yes

Burning Sensation on tongue Yes Sensitivity to cold Yes

Chew on one side of mouth Yes Sensitivity to heat Yes

Cigarette, pipe, or cigar smoking Yes Sensitivity to sweets Yes

Clicking or popping jaw Yes Sensitivity when biting Yes

Dry mouth Yes Sores or growths in your mouth Yes

Fingernail biting Yes How often do you floss?

Food collection between the teeth Yes How often do you brush?

What kind of dental experiences have you had in the past? Good Bad Average

Please explain below if you wish.

How do you feel about the general condition of your teeth? Poor 1 2 3 4 5 Great

Please explain below if you wish.

How important is it for you to keep your teeth in optimal health, comfort and esthetics?

Not Important 1 2 3 4 5 Very Important

Please explain below if you wish.

Do you consume one or more soft drinks per day? Yes No

How satisfied are you with the appearance of your smile? Not Satisfied 1 2 3 4 5 Very Satisfied

What would you change if there were no obstacles?

Would you be interested in hearing about cosmetic options to whiten or improve your smile? Yes No

#### HEALTH HISTORY

AIDS	Yes	Jaundice	Yes
Anemia	Yes	Jaw Pain	Yes
Arthritis, Rheumatism	Yes	Kidney Disease	Yes
Artificial Heart Valves	Yes	Liver Disease	Yes
Artificial Joints	Yes	Low Blood Pressure	Yes
Asthma	Yes	Mitral Valve Prolapse	Yes
Back Problems	Yes	Nervous Problems	Yes
Bleeding abnormally, with extractions or surgery	Yes	Pacemaker	Yes
Blood Disease	Yes	Women: Are you pregnant?	Yes
Cancer	Yes	Due Date?	
Chemical Dependency	Yes	Are you nursing?	Yes
Chemotherapy	Yes	Psychiatric Care	Yes
Circulatory Problems	Yes	Radiation Treatment	Yes
Congenital Heart Lesions	Yes	Respiratory Disease	Yes
Cortisone Treatments	Yes	Rheumatic Fever	Yes
Cough, persistent, or bloody	Yes	Scarlet Fever	Yes
		Shortness of Breath	Yes

Diabetes	Yes	Sinus Trouble	Yes
Emphysema	Yes	Skin Rash	Yes
Do you wear contact lenses?	Yes	Special Diet	Yes
Epilepsy	Yes	Stroke	Yes
Fainting or Dizziness	Yes	Swelling of Feet or Ankles	Yes
Glaucoma	Yes	Swollen Neck Glands	Yes
Headaches	Yes	Thyroid Problems	Yes
Heart Murmur	Yes	Tonsilitis	Yes
Heart Problems	Yes	Tuberculosis	Yes
Hepatitis Type:		Tumor or growth on head or neck	Yes
Herpes	Yes	Ulcer	Yes
High Blood Pressure	Yes	Venereal Disease	Yes
HIV Positive	Yes	Weight Loss Unexplained	Yes

#### MEDICATIONS

List medications you are currently taking:

Pharmacy Name:

Pharmacy Phone:

#### ALLERGIES

Aspirin	Yes
Barbituates (sleeping pills)	Yes
Codeine	Yes
Iodine	Yes
Latex	Yes
Local Anesthetic	Yes
Penicillin	Yes
Sulfa	Yes
Other	