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ADULT NEW PATIENT FORM

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can care for you.

1

ABOUT YOU

Today's Date: _____

Name: _____
Last First

I prefer to be called: _____ Male Female
 DL#: _____

Birth date: _____ Age: _____
 SS# - - _____

Home Address: _____

Single Married Divorced Widowed Separated

Home Phone: _____

Work Phone: _____ Ext: _____

Cell Phone: _____

E-mail: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____
 Where and when are the best times to reach you?

Who may we thank for referring you? _____

Other family members seen by us? _____

Previous/Present Dentist: _____

2

SPOUSE INFORMATION

Their name: _____

Employer: _____

Work Phone: _____ Ext: _____

Cell Phone: _____ Birth date: _____

SS# - - _____ DL#: _____

Person Responsible for accounts:

Name: _____

Billing Address: _____

Work Phone: _____ Ext: _____

Cell Phone: _____

Relationship to patient: _____

SS# - - _____ DL#: _____

Employer: _____

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DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone # _____

Group # (Plan, Local or Policy #) _____

ID # _____

Insured's Name: _____

Insured's Birth Date & SS# _____

Relationship to patient: _____

Insured's Address: _____

Secondary Dental Insurance Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone# _____

Group# (Plan, Local or Policy #) _____

ID # _____

Insured's Name: _____

Relationship to patient: _____

Birth date: _____

SS# - - _____

Insured's Employer: _____

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MEDICAL HISTORY

Do you have a personal physician? No Yes

Physician's Name: _____

Phone # _____ Date of Last Visit: _____

Your current physical health Good Fair Poor

Are you currently under the care of a Physician? No Yes

Please explain: _____

Are you taking any prescription / over-the-counter drugs?

No Yes

List each one: _____

For Women:

Are you taking birth control pills? No Yes

Are you Pregnant? No Yes Week? _____

Are you Nursing? No Yes

Have you ever had any of the following diseases or

- Y N Heart Attack/Stroke
- Y N Psychiatric Problems
- Y N Cancer / Chemotherapy
- Y N Heart Murmur
- Y N Diabetes / Tuberculosis (TB)
- Y N Rheumatic Fever
- Y N Drug / Alcohol Abuse
- Y N HIV+ / AIDS
- Y N Venereal Disease
- Y N Heart Surgery / Pacemaker
- Y N Hemophilia / Abnormal Bleeding
- Y N Shingles
- Y N Ulcers / Colitis
- Y N Mitral Valve Prolapse
- Y N Congenital Heart Defect
- Y N Kidney Problems
- Y N Anemia / Radiation Treatment
- Y N Artificial Bones / Joints
- Y N Asthma / Arthritis
- Y N Artificial Valves
- Y N Difficulty Breathing
- Y N Sinus Problems
- Y N Hospitalized for any Reason
- Y N High / Low Blood Pressure
- Y N Hepatitis

Y N Fever Blisters

Y N Blood Transfusion

Y N Severe / Frequent Headaches

Y N Emphysema / Glaucoma

Y N Epilepsy / Seizures / Fainting Spells

Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following?

Y N Penicillin

Y N Tetracycline

Y N Latex

Y N Aspirin

Y N Dental
Anesthetics

Y N Codeine

Y N Erythromycin

Y N Other

Please list any other drugs that you are allergic to: _____

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DENTAL HISTORY

Why have you come to the dentist today?

Are you currently in pain? No Yes

Have you ever had a serious / difficult problem associated with any previous dental work? No Yes

Do you now or have you ever experienced pain / discomfort in you jaw joint (TMJ)/(TMJD) No Yes

Your current dental health is: Good Fair Poor

Do you like your smile? No Yes

Do your gums bleed? No Yes

How many time a week do you floss? _____

How many time a day do you brush? _____

Type of Bristles? hard medium Soft

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment

Signature

Date

! Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help

**OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC AND THE ADA
Payment is due in full at the time of treatment unless prior arrangements have been approved.**