New Patient Form(s)

Patient Information

First Name
-

Middle Name
-

Last Name
-

Preferred Name
-

Date of Birth
-

Gender
-

Email
-

Business/Cell Phone
-

Home Phone
-

Address
-

City
-

State
-

ZIP Code
-

Occupation
-

Height
-

Weight
-

Insurance Company Name
-

Relationship to Patient
-

Insurance Id
-

SS# or Patient ID
-

Emergency Contact
-

Phone
-

Today's Date
-

Your Name
-

Relationship
-

Medical Conditions

Do you have or have you had any of the following medical conditions?
Choose *Don't Know* if you don't know or not sure of the answer to any question

Persistent cough greater than a 3 week duration
-

Active COVID or flu like illnesses
-

Cough that produces blood
-

Been exposed to anyone with tuberculosis
-

If you answered YES to any of the previous 4 questions please visit your nearest ER

Dental Information

What is the reason for your dental visit today?
-

Date of your last dental exam
-

Date of last dental x-rays
-

What was done at that time?
-

Are you currently experiencing dental pain or discomfort?
-

Have you ever had a serious injury to your head or mouth?
-

Do your gums bleed when you brush or floss?
-

Are your teeth sensitive to cold, hot, sweets or pressure?
-

Does your mouth ever feel dry?
-

Do you have sores or ulcers in your mouth?
-

Have you ever considered whitening your teeth?
-

Do you ever find yourself grinding your teeth?
-

Have you ever had a 3D scan of inside your mouth?
-

Would a same day custom made nightguard interest you?
-

Have you ever considered orthodontic treatment? (Standard, clear, or sublingual braces)
-

Have you ever had any problems with previous dental treatment(s)?
-

Do you drink TAP water?
-

Do you drink bottled or filtered water?
-

If yes, how often do you drink bottled or filtered water?
-

Do you have any ear or neck pain(s)?
-

Do you have any clicking, popping or discomfort in the jaw?
-

Do you wear any full or partial dentures?
-

How do you feel about your smile?
-

Are you now under the care of a physician?
-

Physician Name
-

Phone
-

Address/City/State/Zip
-

Are you in good health?
-

Has there been any change in your general health within the past year?
-

If yes, what condition is being treated?
-

Date of last physical exam
-

Have you had a serious illness, operation or been hospitalized in the past 5 years?
-

If yes, what was the illness or problem?
-

Are you taking or have you recently taken any prescription or over the counter medicine(s)?
-

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements
-

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?
-

Date
-

If yes, have you had any complications?
-

Do you have a history of osteoporosis or Paget's disease?
-

Date Treatment began
-

Do you use controlled substances (drugs)?
-

Do you use tobacco (smoking, snuff, chew, bidis)?
-

Do you consume cannabis? Either through smoke, vape, edibles, etc.
-

Do you drink alcoholic beverages?
-

Allergies

Are you allergic to or have you had a reaction to?

If you answer YES to any of the following allergies, please specify their reaction, too.

Local anesthetics
-

Aspirins
-

-

Penicillin or other antibiotics
-

Sulfa drugs
-

-

Codeine or other narcotics
-

-

Metals
-

-

Latex (rubber)
-

-

Iodine
-

Hay fever/seasonal
-

-

Animals
-

-

Food
-

-

Would you be interested in Botox applications?
-

Would you be interested in facial fillers?
-

Congenital heart disease (CHD)

Artificial (prosthetic) heart valve
-

Previous infective endocarditis
-

Damaged valves in transplanted heart
-

Unrepaired, cyanotic CHD
-

Repaired (completely) in last 6 months
-

Repaired CHD with residual defects
-

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD

Cardiovascular disease
-

Angina
-

Arteriosclerosis
-

Congestive heart failure
-

Damaged heart valves
-

Heart attack
-

Heart murmur
-

Low blood pressure
-

High blood pressure
-

Other congenital heart defects
-

Mitral valve prolapse
-

Pacemaker
-

Rheumatic fever
-

Rheumatic heart disease
-

Abnormal bleeding
-

Anemia
-

Blood transfusion
-

If yes, please mention the date of blood transfusion
-

Hemophilia
-

AIDS or HIV infection
-

Arthritis
-

Autoimmune disease
-

Rheumatoid arthritis
-

Systemic lupus erythematosus
-

Asthma
-

Bronchitis
-

Emphysema
-

Sinus trouble
-

Tuberculosis
-

Cancer/Chemotherapy/ Radiation Treatment
-

Chest pain upon exertion
-

Chronic pain
-

Diabetes Type I or II
-

Eating disorder
-

Malnutrition
-

Gastrointestinal disease
-

G.E. Reflux/persistent heartburn
-

Ulcers
-

Thyroid problems
-

Stroke
-

Glaucoma
-

Hepatitis, jaundice or liver disease
-

Epilepsy
-

Fainting spells or seizures
-

Neurological disorders
-

If yes, specify
-

Sleep disorder
-

Do you snore?
-

Would you be interested in a nightguard for your snoring?
-

Mental health disorders
-

Specify
-

Recurrent Infections
-

Kidney problems
-

Persistent swollen glands in neck
-

Any photosensitivity?
-

Severe or rapid weight loss in the past 6 months?
-

Ongoing sexually transmitted diseases
-

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?
-

Name of physician or dentist making recommendation
-

Phone
-

FOR WOMEN ONLY

-

Are you pregnant?
-

Number of weeks
-

Taking birth control pills or hormonal replacement?
-

Are you nursing?
-

Do you have any disease, condition, or problem not listed above that you think I should know about?
-

NOTE: Both the doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.

I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Responsible Party

If you are filling out this form on behalf of another person, please mention your name and your relationship with that person

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Signature of the Patient/Legal Guardian (ESign)

Date :

FOR OFFICE USE ONLY

Signature of the Dentist (ESign)

Date
-

Date :

Payments

Card On File

Card Holder Name	Card Number	Expiry Date	Security Code
-	-	-	***

Country
-